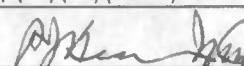


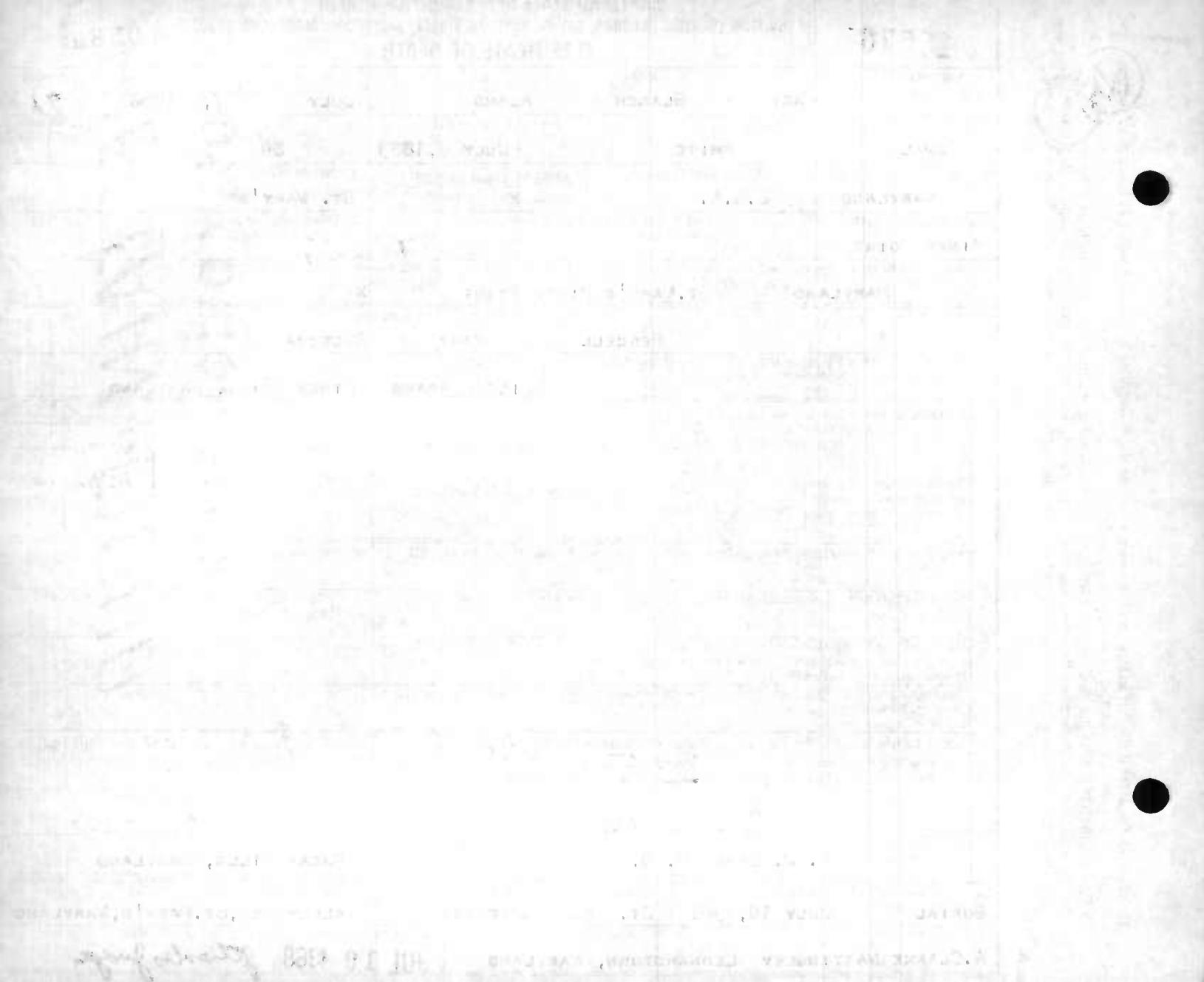
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First MARY	Middle BLANCH	Last ADAMS	2a. DATE OF DEATH Month JULY	2b. HOUR Year 7, 1968	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 9, 1883	6. AGE (In years last birthday) 84	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S		
10. CITY OR TOWN OF DEATH PINEY POINT		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN PINEY POINT	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First ?		Middle PERCELL	Lost	15. MOTHER'S MAIDEN NAME First Middle MARY REBECCA	Lost ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MILTON ADAMS			Address PINEY POINT, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and, (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 4109 (b) <u>Coronary sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>July</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>July 7/68</u>		
22d. PHYSICIAN'S NAME (Type) P. J. BEAN M. D.		22e. ADDRESS GREAT MILLS, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 10, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ST. GEORGE CEMETERY		23d. LOCATION (City or Town) (County) (State) VALLEY LEE, ST. MARY'S, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				ADDRESS LEONARDTOWN, MARYLAND	25a. REC'D BY REGISTRAR JULY 10 1968	25b. REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

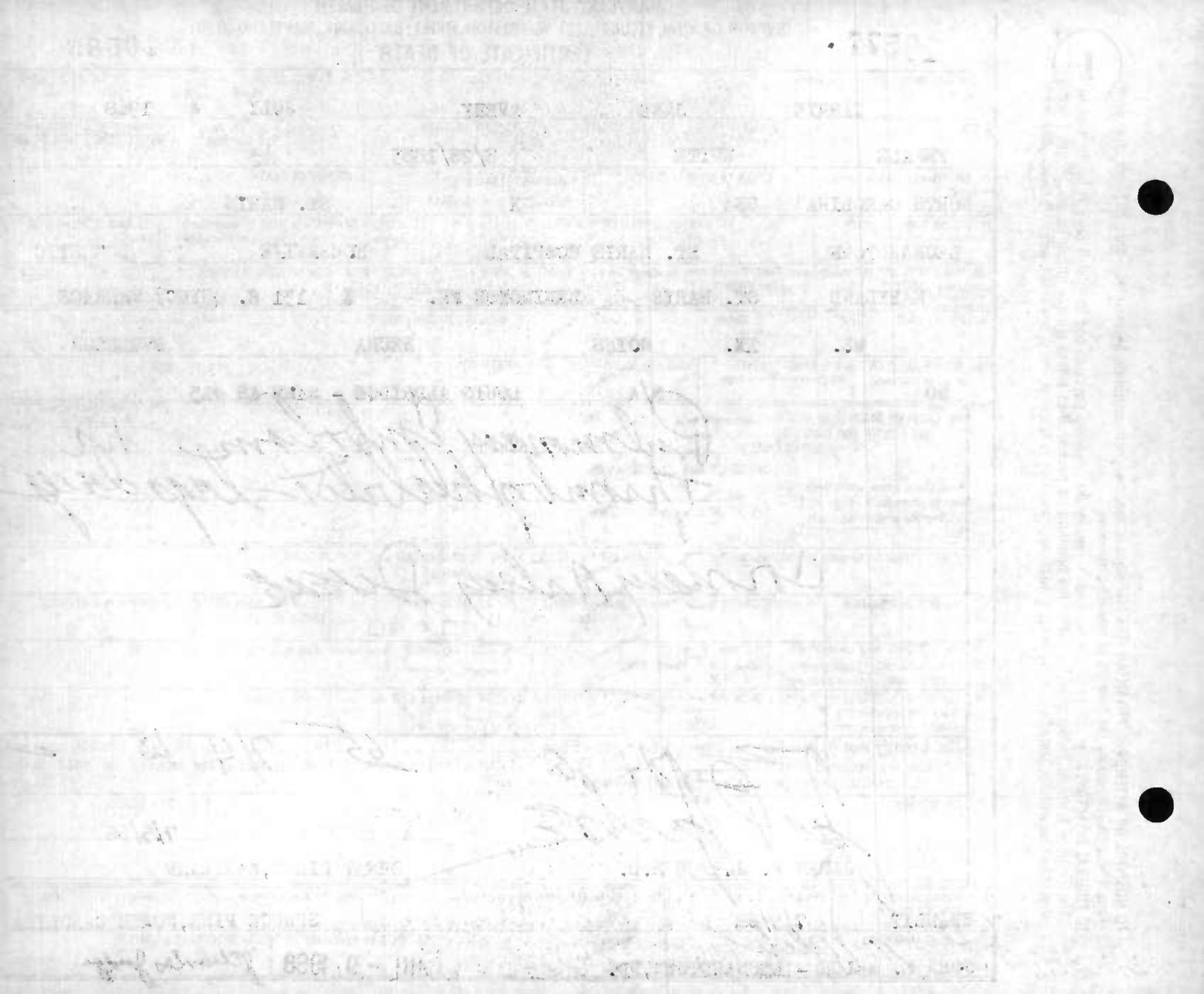
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10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First CARRIE	Middle JANE	Last EVERY	2a. DATE OF DEATH Month JULY	Day 4	Year 1968	2b. HOUR M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 8/28/1885			6. AGE (In years last birthday) 82	IF UNDER 1 YEAR MONTHS 82	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH ST. MARYS				
10. CITY OR TOWN OF DEATH LEONARDTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARYS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ST. MARYS	13c. CITY OR TOWN LEXINGTON PK.	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 131 E. QUINCY TERRACE			
14. FATHER'S NAME WM.	First XM.	Middle GOINS	Last	15. MOTHER'S MAIDEN NAME BEUNA	Middle	Last BURLESON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. NA	17. INFORMANT LOUIS ALDRIDGE	Address SAME AS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4510 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost. (b) DUE TO, OR AS A CONSEQUENCE OF Pulmonary Embolism Thrombophlebitis legs (c) DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 463X							
19a. DATE OF OPERATION 463X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (his hospital) attended the deceased from 1965 to 1968 , that (I) (we) last saw the deceased alive on 7/4/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE JAMES P. JARBOE	DEGREE MD.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 7/5/68		
22d. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M.D.	22e. ADDRESS GREAT MILLS, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT	23b. DATE 7/5/68	23c. NAME OF CEMETERY OR CREMATORIAL SPRUCE PINE, NORTH CAROLINA	23d. LOCATION (City or Town) SPRUCE PINE, NORTH CAROLINA	(County)	(State)		
24. FUNERAL DIRECTOR JOHN M. WELCH	ADDRESS LEONARDTOWN, MD.	25a. REC'D BY REGISTRAR DATE - 9 1968	25b. REGISTRAR'S SIGNATURE Charles Judge				



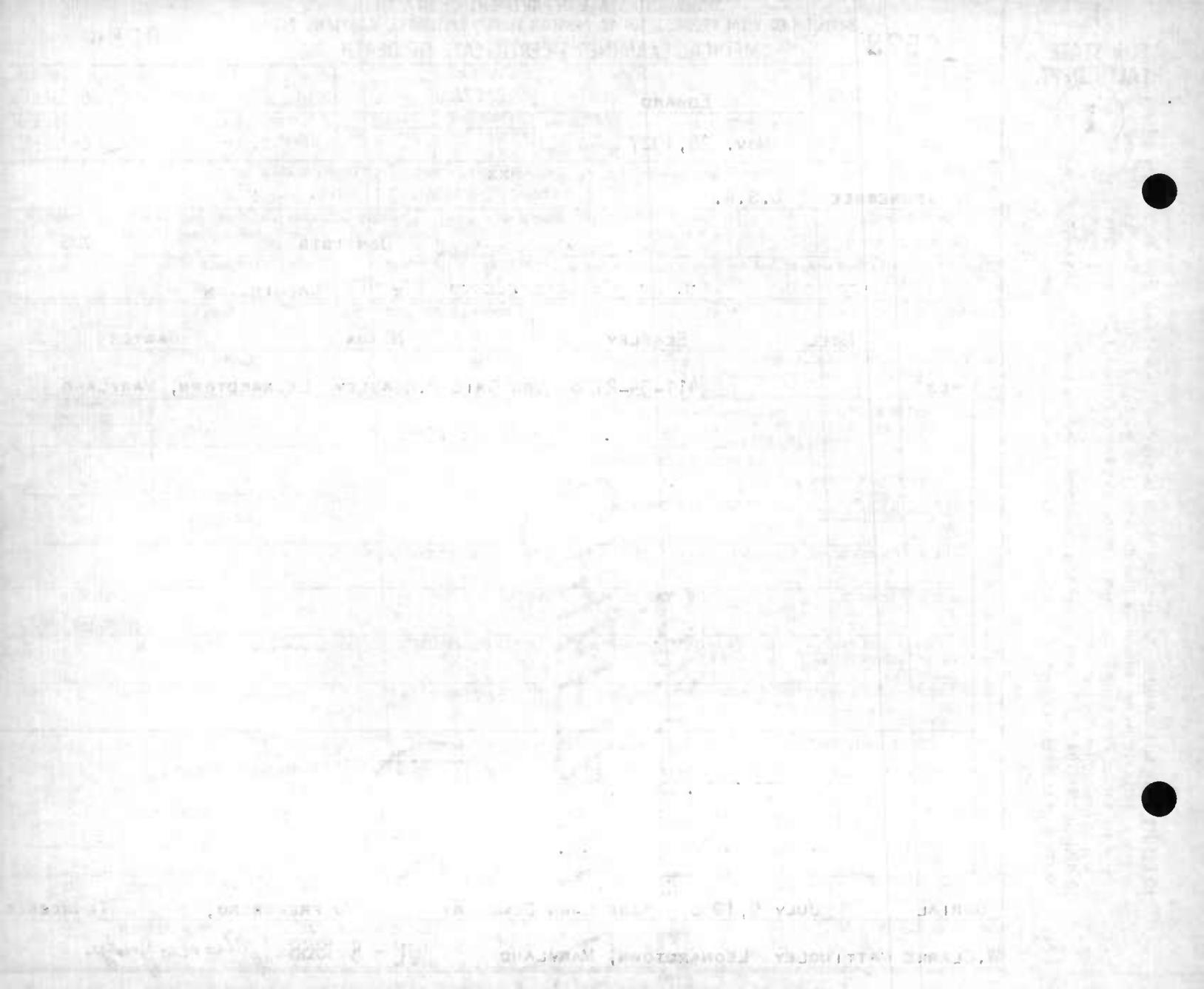
FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMG. Page 5 may be retained for your files.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)		First HULON			Middle EDWARD		Lost BEASLEY			2a. DATE KNOWN <input type="checkbox"/> Month July 4, 1968	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 26, 1927		6. AGE (in years last birthday) 40 yrs		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH St. Mary's		2c. DATE PRONOUNCED DEAD Month July Day 4, Year 1968		2d. HOUR 10:15 P.M.	
10. CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Mary's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DENTISTS			12b. KIND OF BUSINESS OR INDUSTRY DDS		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Leonardtown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER WASHINGTON			
14. FATHER'S NAME NOEL		First MIDDLE BEASLEY		Lost		15. MOTHER'S MAIDEN NAME NORMA		Middle			Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 411-34-2128		17. INFORMANT Mrs ORIE P. BEASLEY		ADDRESS LEONARDTOWN, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4109											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCD</u>											
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION 4201		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 9, 1968		23c. NAME OF CEMETERY OR CREMATORIAL ROSE LAWN CEMETERY		23d. LOCATION (City or Town) MURFREESBORO,		(County) TENNESSEE		(State)	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					





18579

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10587

1. DECEASED-NAME (Type or print)			First GRACE	Middle MILLER	Last BEDELL	2a. DATE OF DEATH Month JULY	Day 14	Year 1968	2b. HOUR Md.			
3. SEX FEMALE		4. RACE WHITE	5. DATE OF BIRTH 8/30/1885			6. AGE (In years last birthday) 82		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7b. BIRTHPLACE (State or foreign country) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH ST. MARYS						
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARYS NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARYS		13c. CITY OR TOWN CHARLOTTE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME WILLIAM		First J	Middle MILLER	15. MOTHER'S MAIDEN NAME MARY		First GRACE		Middle SCOTT	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT 577 09 8418D		17. INFORMANT NURSING HOME RECORDS		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerosis C-V Disease</i>												
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ last: <i>4221</i>										DUE TO, OR AS A CONSEQUENCE OF		
(c) _____										DUE TO, OR AS A CONSEQUENCE OF		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>G & D tract</i>												
19a. DATE OF OPERATION <i>1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 1957</i> , to <i>Oct 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <i>7/14/68</i>		
22b. SIGNATURE <i>Mossman M.D.</i>		22c. DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.						
22d. PHYSICIAN'S NAME (Type) <i>D.L. Mossman</i>		22e. ADDRESS <i>Mechanicsville, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur 1a		23b. DATE 7/16/68		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cem.		23d. LOCATION (City or Town) Rockville		(County) Mont.		(State) Md.		
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS 7557 Beth. C. Ave. Md.		25a. REC'D BY REGISTRAR JUL 16 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please ~~copy~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

Death any delay is
Pages 1, 2, and 3 to
with form PM3. Page
State Department

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is discovered. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the certificate. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Chief Medical Examiner's Office. Page 3 should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the certificate. Page 3 should be retained for your files.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN <input type="checkbox"/> Month July Year 1968 OF ESTI- DEATH MATED <input type="checkbox"/> JULY 28, 1968	2b. HOUR M	
DOYLE		ERNEST		BENFIELD			
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH FEB. 27, 1919	6. AGE (In years last birthday) 49	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> 0 YRS. <input type="checkbox"/> 4	IF UNDER 24 HRS. HOURS <input type="checkbox"/> 0 MIN. <input type="checkbox"/> 0	2c. DATE PRONOUNCED DEAD Month July Day 28, Year 1968	2d. HOUR M
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ST. MARY'S	
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SAWER LUMBER MILL		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13c. CITY OR TOWN ST. MARY'S MORGANZA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME CHRISTOPHER		Middle	Last	15. MOTHER'S MAIDEN NAME MAGGIE		Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 240 30 4395		17. INFORMANT RUBY LEE BENFIELD		ADDRESS MORGANZA, MARYLAND	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>4109</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) _____</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><i>4201 Coronary sclerosis</i></p>							
19a. DATE OF OPERATION <i>4/20/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
<p>22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>P. J. Bean M. D.</i></p> <p>EXAMINER'S NAME (Type) P. J. BEAN M. D.</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.</p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>ADDRESS (Street, city, town, or county) <i>Post Office, St. Mary's, Md.</i></p>							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 31, 1968		23c. NAME OF CEMETERY OR CREMATORIAL First Baptist Church Cem.		23d. LOCATION (City or Town) (County) (State) Lenoir, Caldwell Co., N. C.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE AUG 1 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

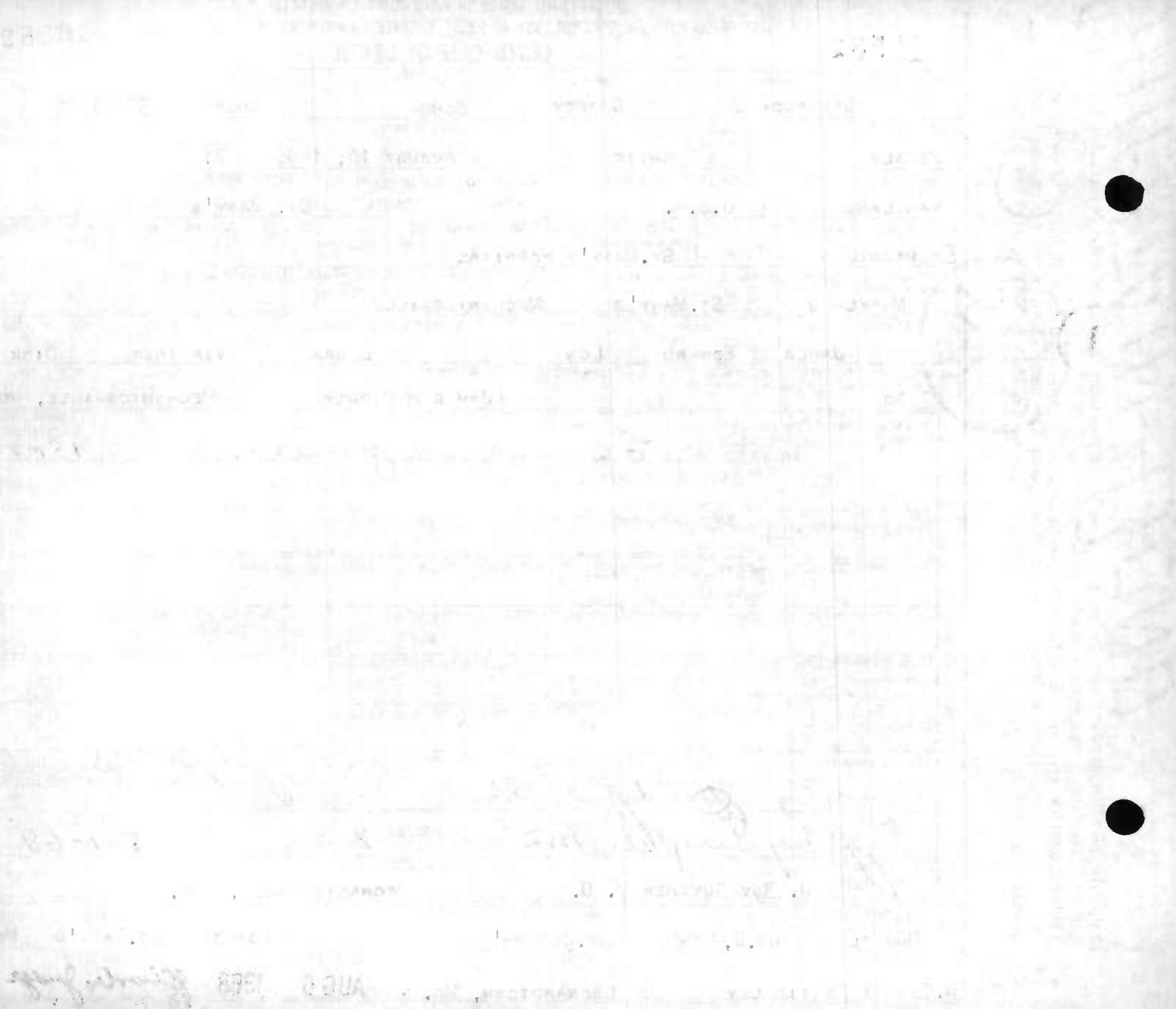
CERTIFICATE OF DEATH

10589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and 2 from this certificate, within 72 hours after death.

1		10581		23d. LOCATION (City or Town) (County) (State) MORGANZA ST. MARY'S MD.		2b. HOUR 30 1968		
1. DECEASED-NAME (Type or print)		First GERTRUDE E	Middle COPSEY	Lost BOND	2a. DATE OF DEATH Month JULY	Day 30	Year 1968	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 16, 1896		6. AGE (In years last birthday) 71 YRS.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ST. MARY'S		
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN MECHANICSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER MECHANICSVILLE, Md.		
14. FATHER'S NAME First JAMES		Middle EDWARD	Last LONG	15. MOTHER'S MAIDEN NAME First LAURA		Middle VIRGINIA	Last DICK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT JAMES H COPSEY		Address MECHANICSVILLE, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma pancreas APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos								
157.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157X								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from July 30, 1968 , to July 30, 1968 , that (I) (we) last saw the deceased alive on July 30, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Roy Guyther, M.D.								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS MECHANICSVILLE, Md.		22c. DATE SIGNED 8-1-68				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Aug. 2, 1968		23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S				
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				ADDRESS LEONARDTOWN, Md.		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 3. Page 5 may be retained for your files.

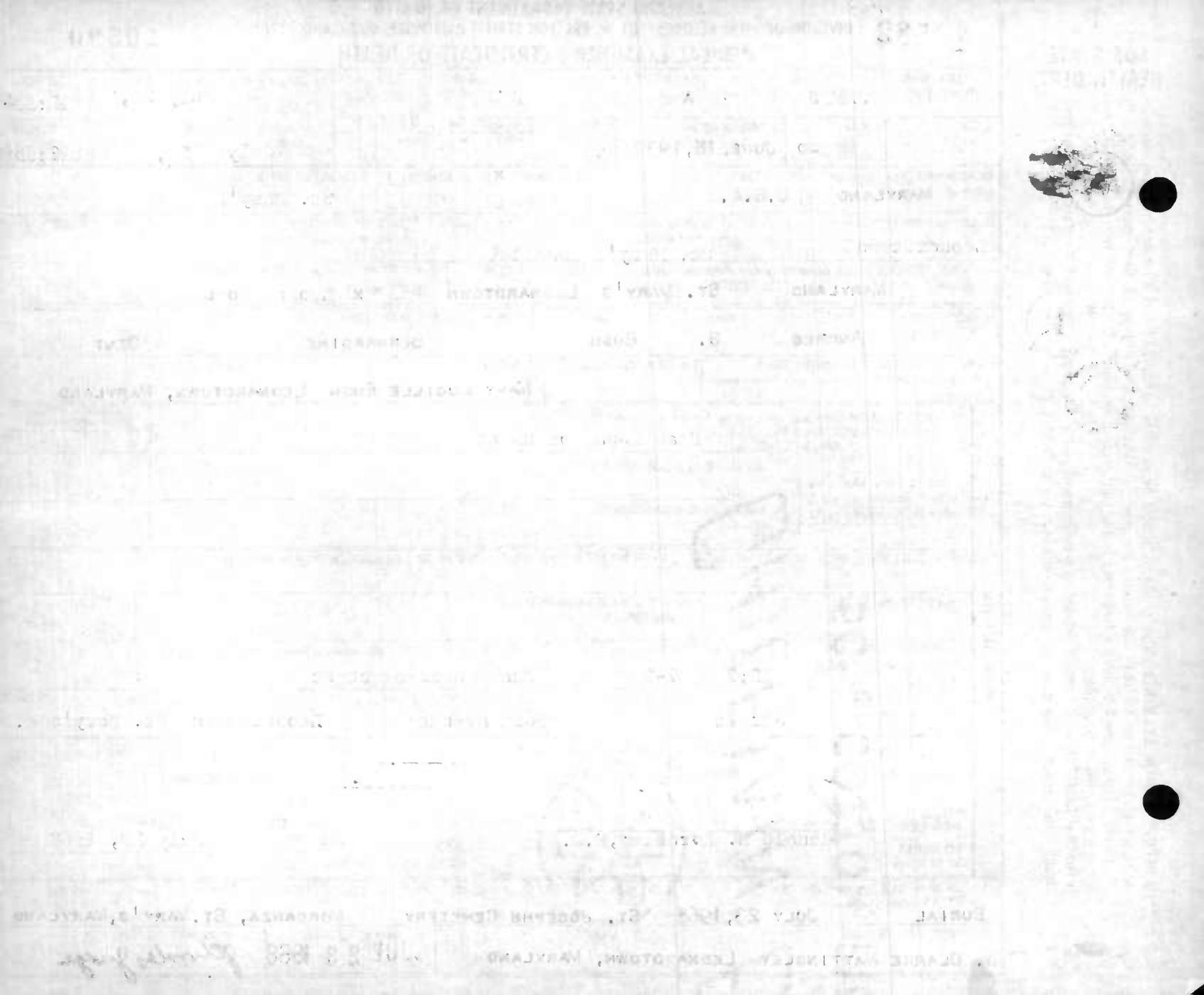
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

10582 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10590

1. DECEASED-NAME (Type or Print)			First JAMES	Middle A	Last BUSH	2a. DATE KNOWN OR ESTI- MATED	Month July	Day 20,	Year 1968	2b. HOUR 12:55A	
3. SEX Male	4. RACE Negro	S. DATE OF BIRTH JUNE 18, 1939	6. AGE (in years last birthday) 29	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month July				2d. HOUR 12:55A	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH St. Mary's				Md.	
10. CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Mary's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. CITY OR TOWN ST. MARY'S LEONARDTOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Leonardtown		
14. FATHER'S NAME ANDRES S. BUSH			15. MOTHER'S MAIDEN NAME BERNARDINE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT MARY LUCILLE BUSH LEONARDTOWN, MARYLAND			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of Chest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
966X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 982X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:30PM 7-20 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Stab wound of chest					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street			21f. LOCATION Street or R.F.D. No. Park Avenue		City or Town Leonardtown		County St. Mary's M.D.	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> RONALD N. KORNBLUM, M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23b. DATE JULY 23, 1968			23c. NAME OF CEMETERY OR CREMATORIUM ST. JOSEPH'S CEMETERY			23d. LOCATION (City or Town) MORGANZA, ST. MARY'S, MARYLAND			(County)	(State)	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND										25a. REC'D BY REGISTRAR DATE JUL 23 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15ME (5) 10M REV. 1/68											



10583

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10591

Item#11, FilmGL03 7/31/68 km

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First LAURA	Middle HEBB	Last COAD	2. DATE OF DEATH Month JULY	Day 21	Year 1968	2b. HOUR 6:00 PM				
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 7/9/1886			6. AGE (In years last birthday) 82	YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH ST. MARYS								
10. CITY OR TOWN OF DEATH DRAYDEN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DRAYDEN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	13b. COUNTY ST. MARYS	13c. CITY OR TOWN DRAYDEN	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER DRAYDEN							
14. FATHER'S NAME First RICHARD	Middle M.	Last HEBB	15. MOTHER'S MAIDEN NAME First LAURA	Middle COMBS	Last RECOMBS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes or no, or unknown NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215 18 1539	17. INFORMANT MRS. MARGARET JOHNSTONE - MECHANICSVILLE, MD.	Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leucemia											
2079 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2044											
(b) Leucemia											
DUE TO, OR AS A CONSEQUENCE OF (c) Leucemia											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Cerebral Occlusion											
19a. DATE OF OPERATION 1963	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of breast	20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) Not	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Not									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Not	21f. LOCATION Street or R.F.D. No. Not	City or Town Not		County Not		State Not				
22a. I certify that (I) (this hospital) attended the deceased from April , 19 63 , to July 26, 1968 , that (I) (was) last saw the deceased alive on July 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.										22c. DATE SIGNED 7/23/68	
22b. SIGNATURE P. J. BEAN M.D.					22e. ADDRESS GREAT MILLS, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7/24/68	23c. NAME OF CEMETERY OR CREMATORIAL ST. IGNATIUS CEM.	23d. LOCATION (City or Town) ST. IGNATIUS, MARYLAND	(County) MARYLAND	(State) MARYLAND						
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MD.	ADDRESS	25a. REC'D BY REGISTRAR Charles J. Welch	25b. REGISTRAR'S SIGNATURE Charles J. Welch								
DATE JUL 25 1968		DATE JUL 25 1968									

25

0000 2000

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10592

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First JAMES	Middle DANIEL	Last ENNELS	2a. DATE OF DEATH JULY 25	2b. HOUR 2:45 P
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 2/19/1902		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ST. MARYS	
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARYS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. COUNTY ST. MARYS		13c. CITY OR TOWN LEXINGTON PK.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME WALTER		15. MOTHER'S MAIDEN NAME ENNELS		16. OLIVE		17. Address WATTS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 216 12 4111		17. INFORMANT HOSPITAL RECORDS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> <u>2509</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prolongedritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>260x</u>							
19a. DATE OF OPERATION 260x		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John J. Fenwick</u>		DEGREE JOHN F. FENWICK M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 7/26/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS LEONARDTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/29/68		23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHN'S CEM.		23d. LOCATION (City or Town) HOLLYWOOD, MARYLAND (County) (State)	
24. FUNERAL DIRECTOR <u>John M. Welch</u>		ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 30 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. F.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10585

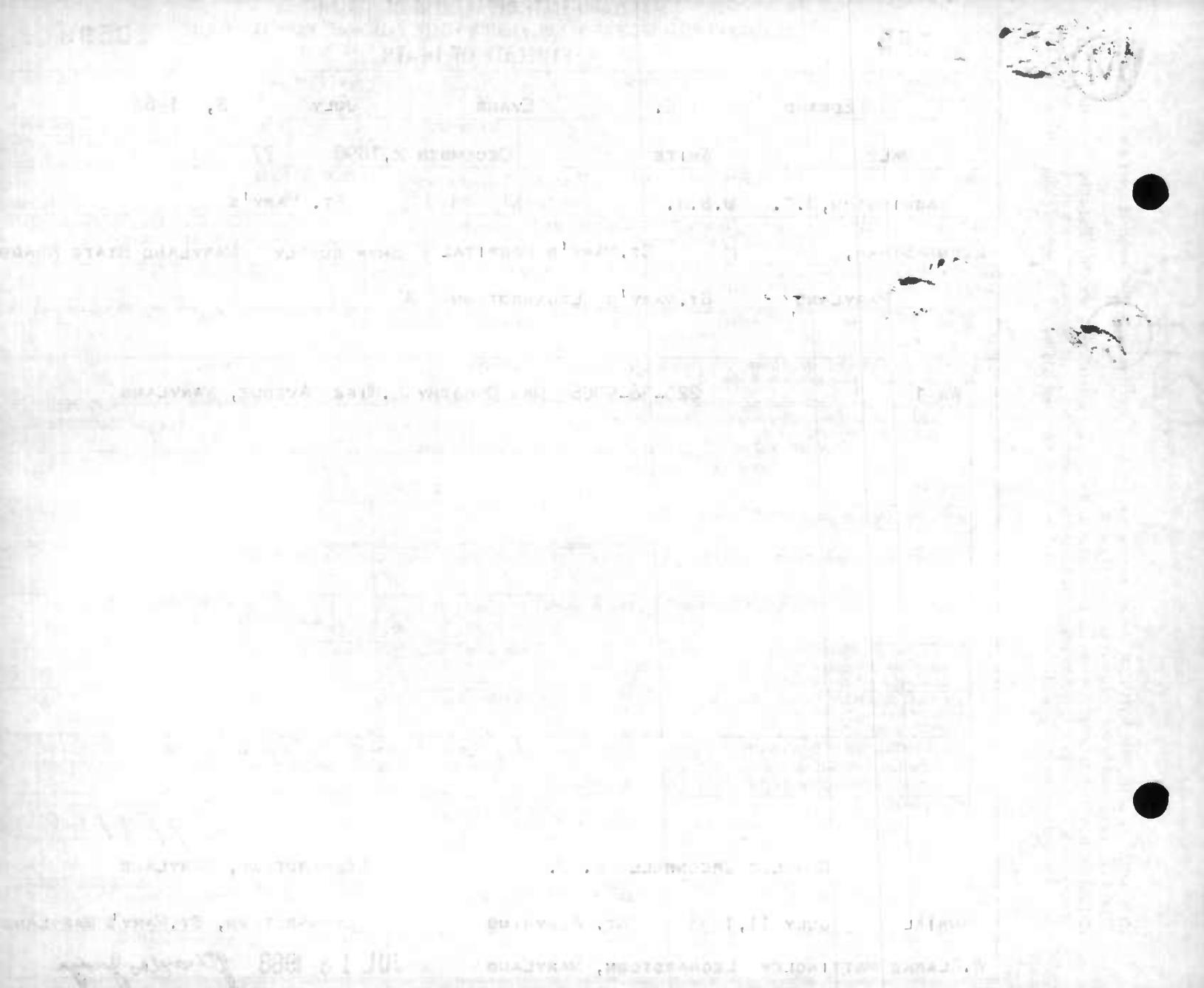
10593

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First EDWARD	Middle E.	Last EVANS	2a. DATE OF DEATH JULY Month 8, Do 1968 Year	2b. HOUR M	
3. SEX MALE		4. RACE WHITE		S. DATE OF BIRTH DECEMBER 2, 1890	6. AGE (In years last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S		
10. CITY OR TOWN OF DEATH LEONARDTOWN,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SHOP SUPPLY		12b. KIND OF BUSINESS OR INDUSTRY MARYLAND STATE ROADS	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEONARDTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME		First Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown W		16b. SOCIAL SECURITY NO. 220-36-9908		17. INFORMANT MRS DOROTHY E. WISE		Address AVENUE, MARYLAND	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i></p> <p>4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardio-vascular disease</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p> <p>4221</p>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 1/6 , 19 59 , to 7/8 , 19 68 , that (I) (we) last saw the deceased alive on 7/8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles Greenwell M.D.</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 7/9/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 11, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ST. ALOYSIUS		23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, ST. MARY'S MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 18 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Mattingley</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10586 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10594

1. DECEASED-NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
MARGARET E GRAY				<input checked="" type="checkbox"/>	7	16	1968	6 p.m.
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			2d. HOUR
Female	White	2-11-1911	57 yrs.	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH					
MARYLAND	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	St. Mary's					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Leonardtown	St. Mary's Hospital				HOUSEWIFE			DOMESTIC
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Md.	ST. MARY'S	Hollywood	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Hollywood, Maryland				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
RICHARD QUADE				FLORA				GRAY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
(If yes give war or dates of service)	577-26-9054							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease								
2509 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Diabetes mellitus								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
260X 19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY YES <input checked="" type="checkbox"/> (head) NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
22b. DATE SIGNED July 17, 1968								
ACTUAL SIGNATURE Edward F. Wilson, M.D.								
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7-19-1968		23c. NAME OF CEMETERY OR CREMATORIUM ST. JOSEPH CEM.		23d. LOCATION (City or Town) (County) (State) MORGANZA ST. MARY'S Md.		
24. FUNERAL DIRECTOR John M. Welch		ADDRESS LEONARDTOWN MARYLAND		25a. REC'D BY REGISTRAR JUL 24 1968			25b. REGISTRAR'S SIGNATURE Charles J. ...	
VR A15ME (51) 10M REV. 1/68								

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

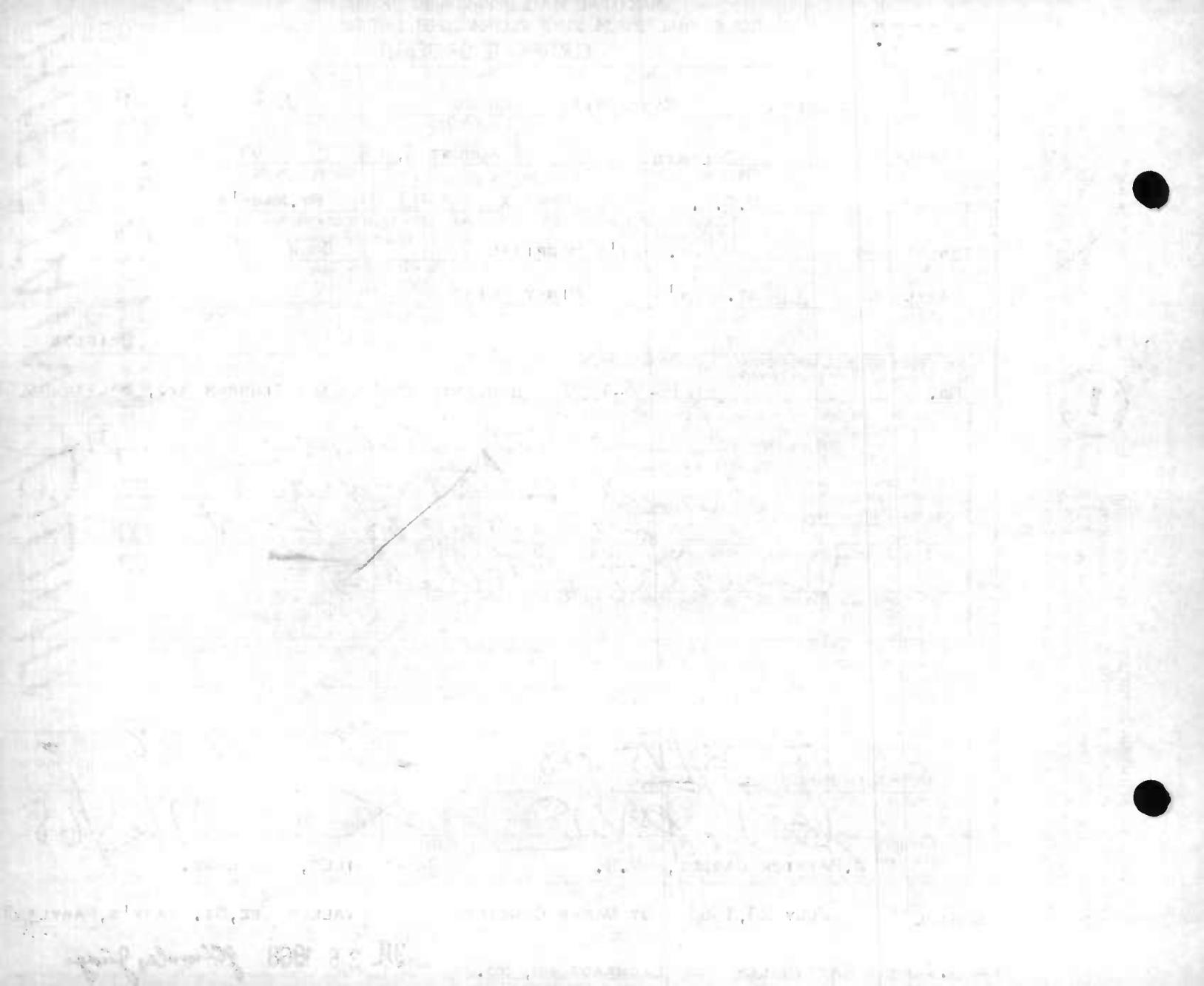
10595

10587

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. And please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MAGGIE		MARGUERITE	GROSS	JULY	19	1968	M
3. SEX	4. RACE		S. DATE OF BIRTH	6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE	COLORED		AUGUST 5, 1874	93	YRS.	MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		IF UNDER 24 HRS.	
MARYLAND	U.S.A.			ST. MARY'S		MONTHS HOURS MIN	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
LEONARDTOWN	ST. MARY'S HOSPITAL			Cook			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
MARYLAND	ST. MARY'S	PINEY POINT	YES <input type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
	?	?		SARAH			BRISCOE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.		17. INFORMANT	Address			
No.	219-56-1350		BENJAMIN GROSS	2323 WINDSOR Av., BALTIMORE M			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Circulatory Collapse						
2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs Days						
(b)	Septicemia						
(c)	Paroxysm of pain						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
260X Diseases Mellitus							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 1967, to _____, 1968, that (I) (did not) last saw the deceased alive on _____, 1968 and that in (my) (appraisal) death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.							
22b. SIGNATURE	Last P. Jarboe						
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS						
J. PATRICK JARBOE, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City or Town)		(County)	(State)
BURIAL		JULY 23, 1968	ST MARKS CEMETERY	VALLEY LEE, ST. MARY'S, MARYLAND			
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. CLARKE MATTINGLEY	LEONARDTOWN, MD.		JUL 26 1968		Charles Judge		



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10588

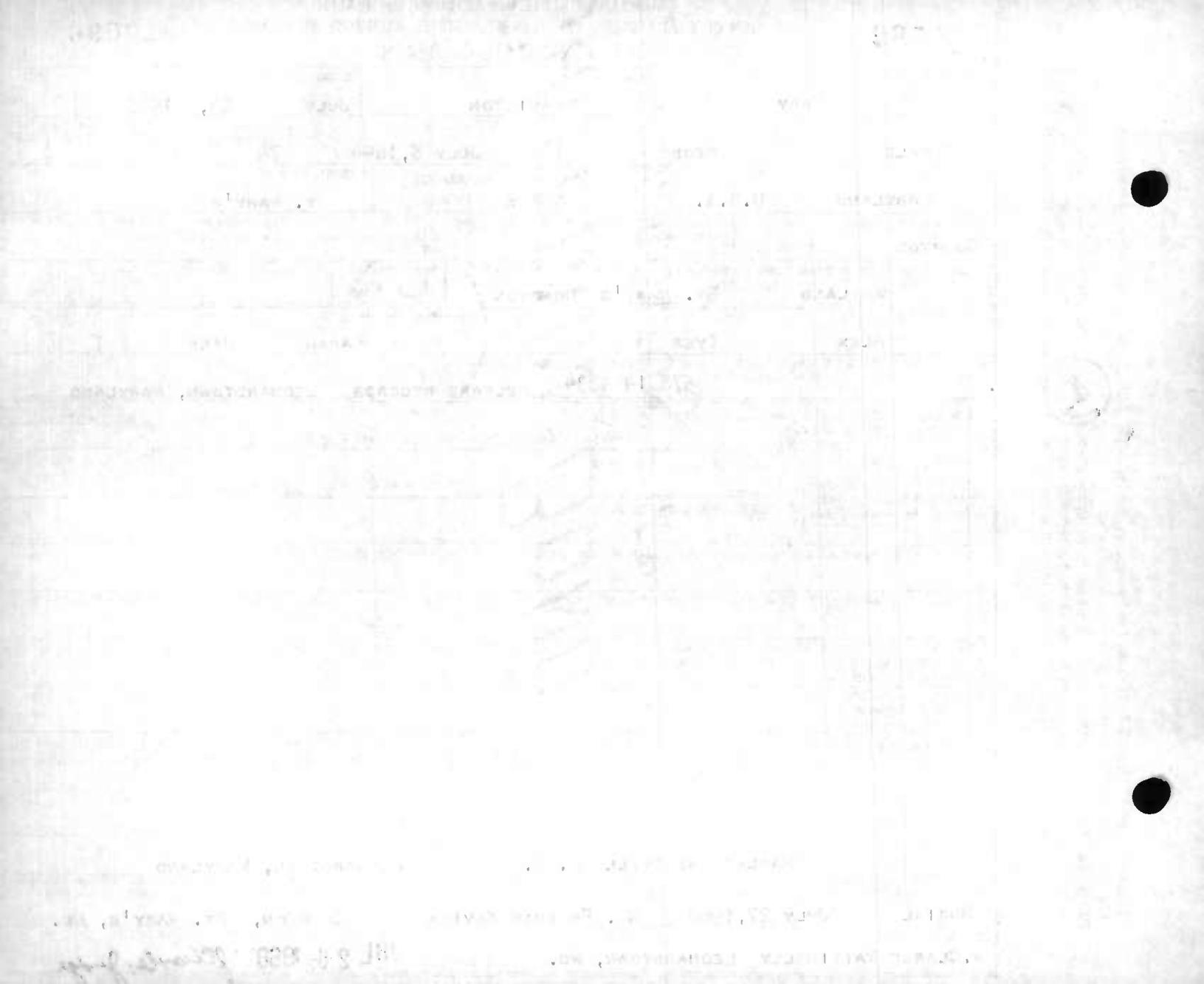
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10596

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First MARY	Middle HAMILTON	Lost	20. DATE OF DEATH Month JULY	Day 24,	Year 1968	2b. HOUR M
3. SEX FEMALE	4. RACE NEGRO	S. DATE OF BIRTH JULY 8, 1894	6. AGE (In years last birthday) 74	7. IF UNDER 1 YEAR MONTHS 00			IF UNDER 24 HRS. HOURS 18
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S	Md.			
10. CITY OR TOWN OF DEATH COMPTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) COMPTON	12b. KIND OF BUSINESS OR INDUSTRY WELFARE RECORDS				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN COMPTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER LEONARDTOWN, MARYLAND			
14. FATHER'S NAME ALEX	First TYER	Middle 	Lost 	15. MOTHER'S MAIDEN NAME SARAH	First JANE	Middle ?	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes, no, or unknown	16b. SOCIAL SECURITY NO. 578 14 4334	17. INFORMANT WELFARE RECORDS	Address LEONARDTOWN, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary Failure</i> APPROXIMATE INTERVAL BETWEEN DISEASE AND DEATH 4129 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) <i>Chidw-Vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION 4/20/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While at work	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) 					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 	21f. LOCATION Street or R.F.D. No. 	City or Town 	County 	State 		
22a. I certify that (I) (this hospital) attended the deceased from July 27, 1968 to July 24, 1968 , that (I) (we) last saw the deceased alive on July 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles Greenwell M.D.</i>	22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 		
22d. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M. D.	22e. ADDRESS LEONARDTOWN, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 27, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ST. FRANCIS XAVIER	23d. LOCATION (City or Town) COMPTON, ST. MARY'S, MD.	(County) 	(State) 		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY	ADDRESS LEONARDTOWN, MD.	25a. REC'D BY REGISTRAR 	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
DATE JUL 26 1968							

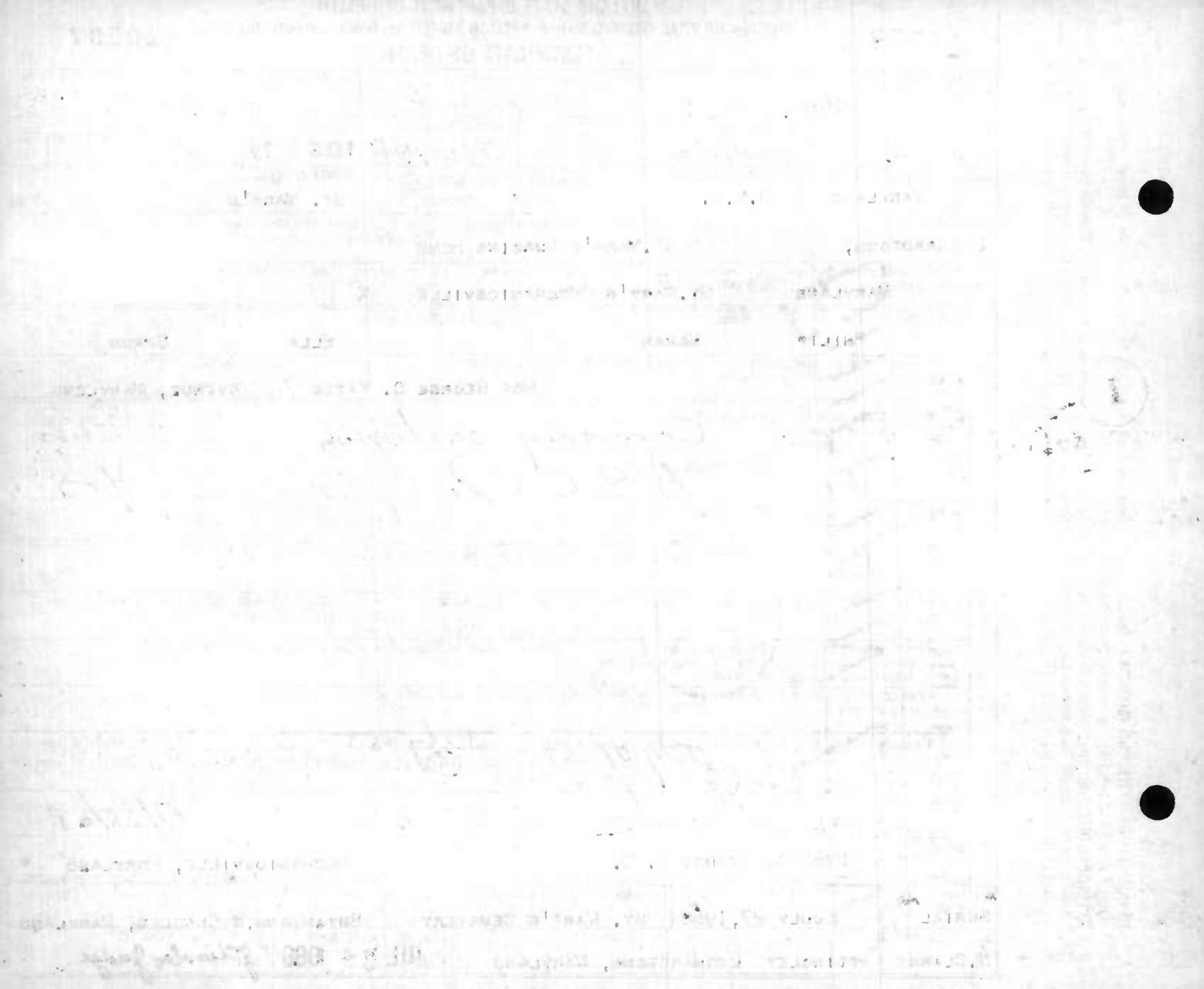


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10589		10597									
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		Month	Doy	Year	2b. HOUR	
Mary		O.	Herbert		7	25	68	4:20	M		
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			IF UNDER 24 HRS.	
Female		white	9/12/1841 1888		79		MONTHS	DAYS	HDURS	MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		NEVER MARRIED	<input type="checkbox"/>	9. COUNTY OF DEATH				
MARYLAND		U.S.A.	<input checked="" type="checkbox"/>		WIDOWED	<input checked="" type="checkbox"/>	ST. MARY'S				
8. MARRIED		9. DIVORCED									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
LEONARDTOWN,		ST. MARY'S NURSING HOME									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
MARYLAND		ST. MARY'S	MECHANICSVILLE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
PHILIP		MORAN			ELLA			SWANN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes, no, or unknown)				MRS GEORGE C. YATES		AVENUE, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Coronary occlusion APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.											
4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A. S. C. V. D. 45											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
4201						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1968, to 19, 19, that (I) (we) last saw the deceased alive on July 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE		Leon W. Berbbeck		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)		LEON W. BERBEC M. D.		22e. ADDRESS		7/25/68					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION (City or Town)		(County)		(State)		
BURIAL		JULY 27, 1968	ST. MARY'S CEMETERY		BRYANTOWN, & CHARLES,		MARYLAND				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. CLARKE MATTINGLEY		LEONARDTOWN, MARYLAND		JUL 26 1968		jCharles Jones					



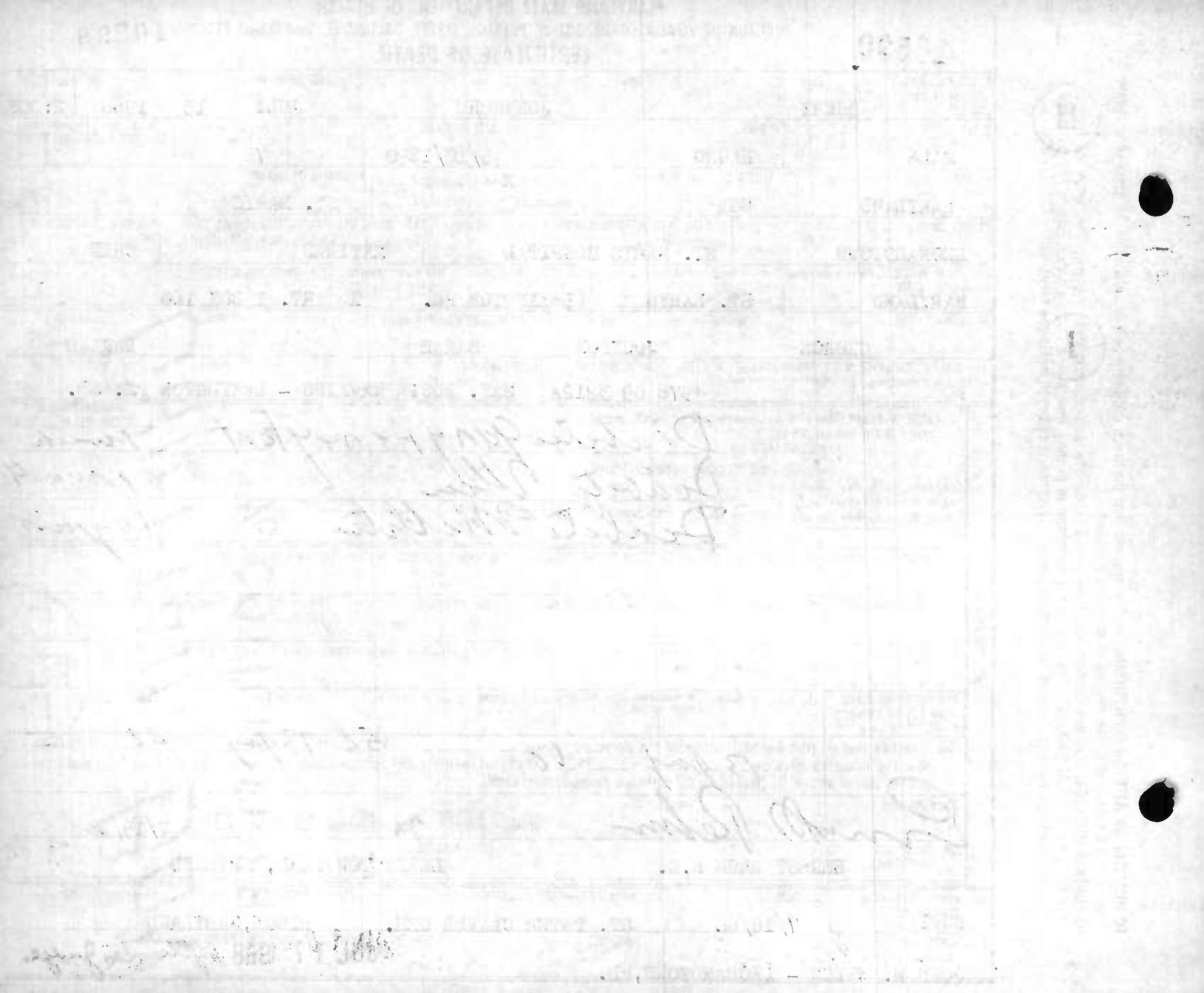
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10598

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED-NAME (Type or print)		First HENRY	Middle	Last JOHNSON	2a. DATE OF DEATH JULY 13 1968	2b. HOUR 2:00P	
3. SEX MALE		4. RACE NEGRO	5. DATE OF BIRTH 5/18/1890		6. AGE (in years last birthday) 78 YRS.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ST. MARYS		
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARYS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY CHEF	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARYS	13c. CITY OR TOWN LEXINGTON PK.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RT. 1 BOX 160		
14. FATHER'S NAME GEORGE		Middle JOHNSON	Last	15. MOTHER'S MAIDEN NAME SARAH	Middle	Last BARNES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578 09 3212A	17. INFORMANT MRS. ROSIE HAWKINS - LEXINGTON PK. MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Diabetes Gangrenous foot				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
2509 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last.		Diabetes Ulcer				1 month	
		Diabetes Melitus				10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
260X		19c. DATE OF OPERATION		19d. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 1968 , to 1968 , 19 68 , that (I) (we) last saw the deceased alive on 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Ernest D. Rehm</i>		DEGREE ERNEST REHM M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 7/15/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS LEXINGTON PARK, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/16/68	23c. NAME OF CEMETERY OR CREMATORIAL ST. PETER CLAVER CEM.		23d. LOCATION (City or Town) RIDGE, MARYLAND		(County) (State)
24. FUNERAL DIRECTOR <i>John M. Welch</i> JOHN M. WELCH - LEONARDTOWN, MD.		ADDRESS		25a. REC'D BY REGISTRAR JUL 17 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

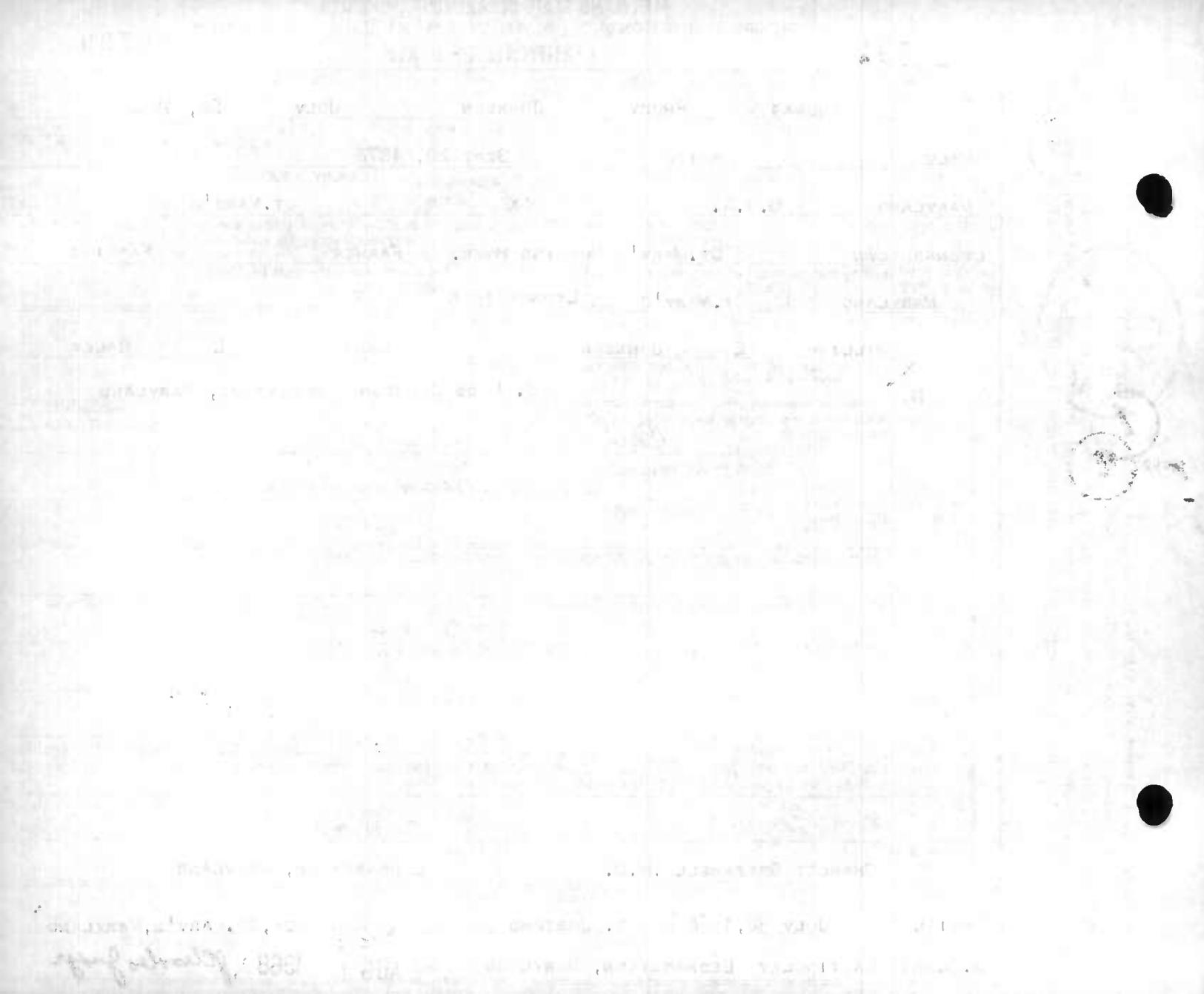
CERTIFICATE OF DEATH

10599

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)		First THOMAS	Middle RHODY	Last JOHNSON	2a. DATE OF DEATH Month JULY	2b. HOUR Day 25, 1968					
3. SEX MALE		4. RACE WHITE	5. DATE OF BIRTH SEPT 20, 1878		6. AGE (In years last birthday) 89	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN. 0		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ST. MARY'S						
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S NURSING HOME.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER							
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEONARDTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER					
14. FATHER'S NAME First WILLIAM		Middle E	Last JOHNSON	15. MOTHER'S MAIDEN NAME First MARY		Middle L	Last RALEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? • Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT J. HEBB JOHNSON		Address HOLLYWOOD, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio-vascular disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4221											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 11/15 , 19 57 , to July 28 , 19 68 , that (I) (we) last saw the deceased alive on July 28 , 19 68 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Charles Greenwell M.D.</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		LEONARDTOWN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 30, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S		23d. LOCATION (City or Town) MORGANZA, ST. MARY'S, MARYLAND		(County)		(State)		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE AUG 1 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

M

10592
1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												10600		
1. DECEASED-NAME (Type or Print)				First	Middle	Last	2a. DATE KNOWN <input type="checkbox"/> Month Day Year				2b. HOUR			
WILLIAM ROBERT JOHNSON							IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS <input type="checkbox"/>	MONTHS	DAYS	HOURS	MIN	JULY 28, 1968 10:30	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)					2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR		
MALE	WHITE	SEPT. 24, 1921	46 yrs.					MONTH	DAY	JULY 28, 1968		10:30		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH								
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ST. MARY'S						Md.		
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY		
LEONARDTOWN				ST. MARY'S HOSPITAL				FARMING, & CARPENTER						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET AND NUMBER		
MARYLAND				ST. MARY'S				LEONARDTOWN				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME				First	Middle	Last	
ERNEST HILLARY JOHNSON							MARY				ROSALIE		COOPER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS		
(If yes give war or dates of service)				219-16-2023				EVA L. JOHNSON				ROUTE 1 Box 276 HOLLYWOOD, Mo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>9509</i> <i>Poisoning (Malathion)</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> last. (b) <i>alcoholism</i> DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) alcoholism														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input checked="" type="checkbox"/> 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>William D. Boyd M.D.</i>		M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>7-31-68</i>				
WILLIAM D. BOYD M. D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION (City or Town) (County) (State)						
BURIAL		JULY 31, 1968		ST. ALOYSIUS CEMETERY				LEONARDTOWN, ST. MARY'S, MARYLAND						
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND												ADDRESS		
												25a. REC'D BY REGISTRAR		
												25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
												DATE AUG 1 1968		
												VR A15ME (5) 10M REV. 1/68		

10593

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10601

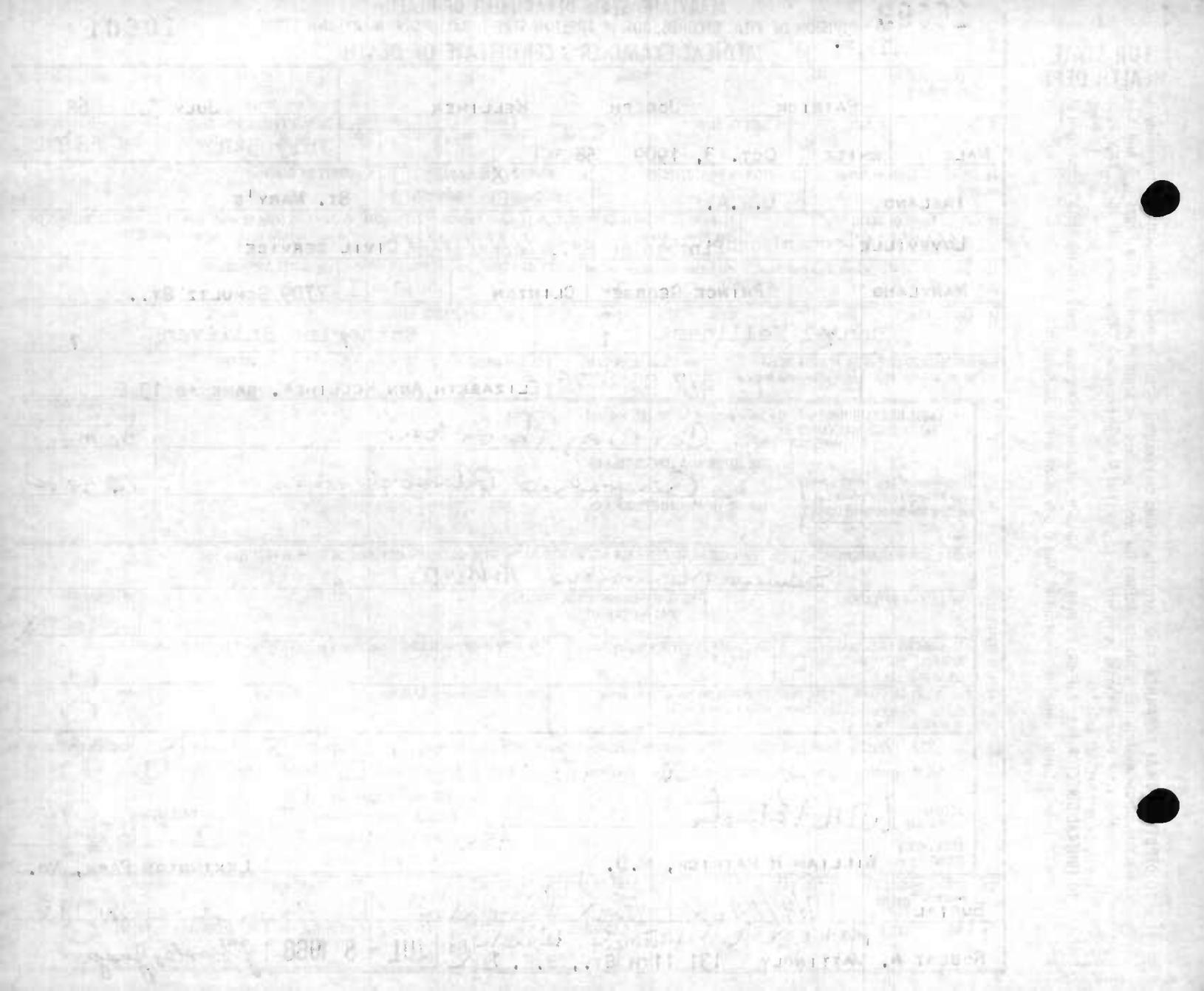
Items#10,11, FilmGL02 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MWZ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
		PATRICK JOSEPH KELLIHER			JULY 5		1968	M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year				2d. HOUR	
MALE	WHITE	OCT. 3, 1909	58 YRS.		July 5th 1968				7 P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH					
IRELAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	ST. MARY'S				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY		
Vivreyville Leonardtown		Pincushion Rd., Leonardtown		CIVIL SERVICE						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
MARYLAND		PRINCE GEORGE		CLINTON		YES <input type="checkbox"/> NO <input type="checkbox"/>		7709 SCHULTZ ST..		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost		
Daniel Kelliher				?	Catherine Sullivan			?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT				ADDRESS		
		77 05 8776		ELIZABETH ANN KELLIHER, SAME AS 13 E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> } last. <u>4109</u> (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 <u>Severe Rheumatoid Arthritis</u>										10 years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?						
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED 7-5-68
ACTUAL SIGNATURE <u>W.H. Patrick</u>		EXAMINER'S NAME (Type) <u>WILLIAM H PATRICK, M.D.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASS. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county) <u>LEXINGTON PARK, MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE <u>7/9/1968</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Fair Springfield</u>		23d. LOCATION (City or Town) <u>Fair Springfield</u>		(County) <u>Prince George's Co.</u>		
24. FUNERAL DIRECTOR ROBERT A. MATTINGLY		ADDRESS <u>131 11TH ST., S.E. D.C.</u>		25a. REC'D BY REGISTRAR <u>JUL - 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jager</u>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

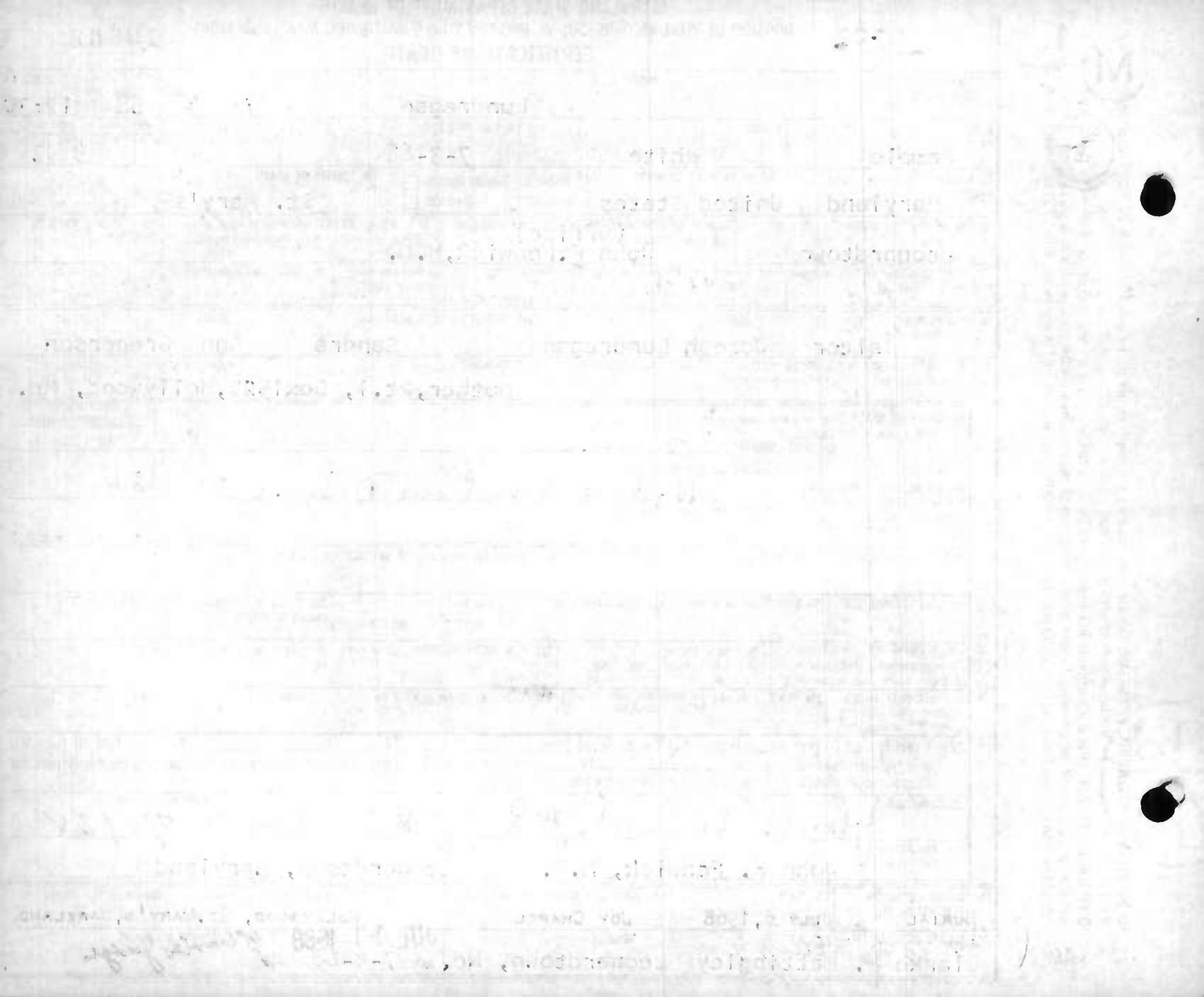
CERTIFICATE OF DEATH

10594

10602

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	20. DATE OF DEATH Month	Day	Year	2b. HOUR A.M. P.M.
			Lundregan	4	68	12:30	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	White	7-3-68		YRS.		9 35	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland	United States			St. Mary's			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
Leonardtown	(Office)			John F. Fenwick, M.D.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Md.	St. Mary's	Hollywood	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
Walter	Joseph	Lundregan		Sandra	Ann	Gregerson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT		Address			
		Mother, Rt. 1, Box 152C, Hollywood, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Anuria</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u>							
(b) <u>Hydrone Nephritis Disease</u> 8 hr.							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19							
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)							
21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John F. Fenwick, M.D.</u>							
22c. DATE SIGNED <u>7/6/68</u>							
22d. PHYSICIAN'S NAME (Type)							
22e. ADDRESS <u>Leonardtown, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)							
23b. DATE <u>JULY 6, 1968</u>							
23c. NAME OF CEMETERY OR CREMATORIAL JOY CHAPEL							
23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, ST. MARY'S, MARYLAND							
24. FUNERAL DIRECTOR <u>Clarke W. Mattingley</u>							
ADDRESS <u>Leonardtown, Md.</u>							
24. REC'D. BY REGISTRY <u>JULY 11, 1968</u>							
24. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							
DATE <u>7-4-68</u>							



10593 1
 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10603

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First ELEANOR	Middle DAVIS	Last MATTINGLY	2a. DATE OF DEATH Month JULY	2b. HOUR Doy 4, 1968
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH AUGUST 29, 1908		6. AGE (In years last birthday) 59	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S		
10. CITY OR TOWN OF DEATH MECHANICSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) TRENT HALL FARM	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MECHANICSVILLE			12b. KIND OF BUSINESS OR INDUSTRY Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN MECHANICSVILLE	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER	
14. FATHER'S NAME First HENRY	Middle DAVIS	Last	15. MOTHER'S MAIDEN NAME First ANNIE	Middle ELIZABETH	Last BOND
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. 21356 4359	17. INFORMANT JOHN THOMAS MATTINGLY	Address MECHANICSVILLE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs.		
2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diseases +					
2509 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes +					
DUE TO, OR AS A CONSEQUENCE OF (c) ASCD					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260X					
19a. DATE OF OPERATION 260X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1955 to 1968, that (I) (we) last saw the deceased alive on 30 Jun 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Leon Berube	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 7/5/68	
22d. PHYSICIAN'S NAME (Type) LEON BERUBE M. D.	22e. ADDRESS MECHANICSVILLE, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 6, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S CEMETERY	23d. LOCATION (City or Town) MORGANZA, ST. MARY'S, MARYLAND	(County) MARYLAND	(State)
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY	ADDRESS LEONARDTOWN, MARYLAND	25a. REC'D BY REGISTRAR JUL - 8 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

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CERTIFICATE OF DEATH

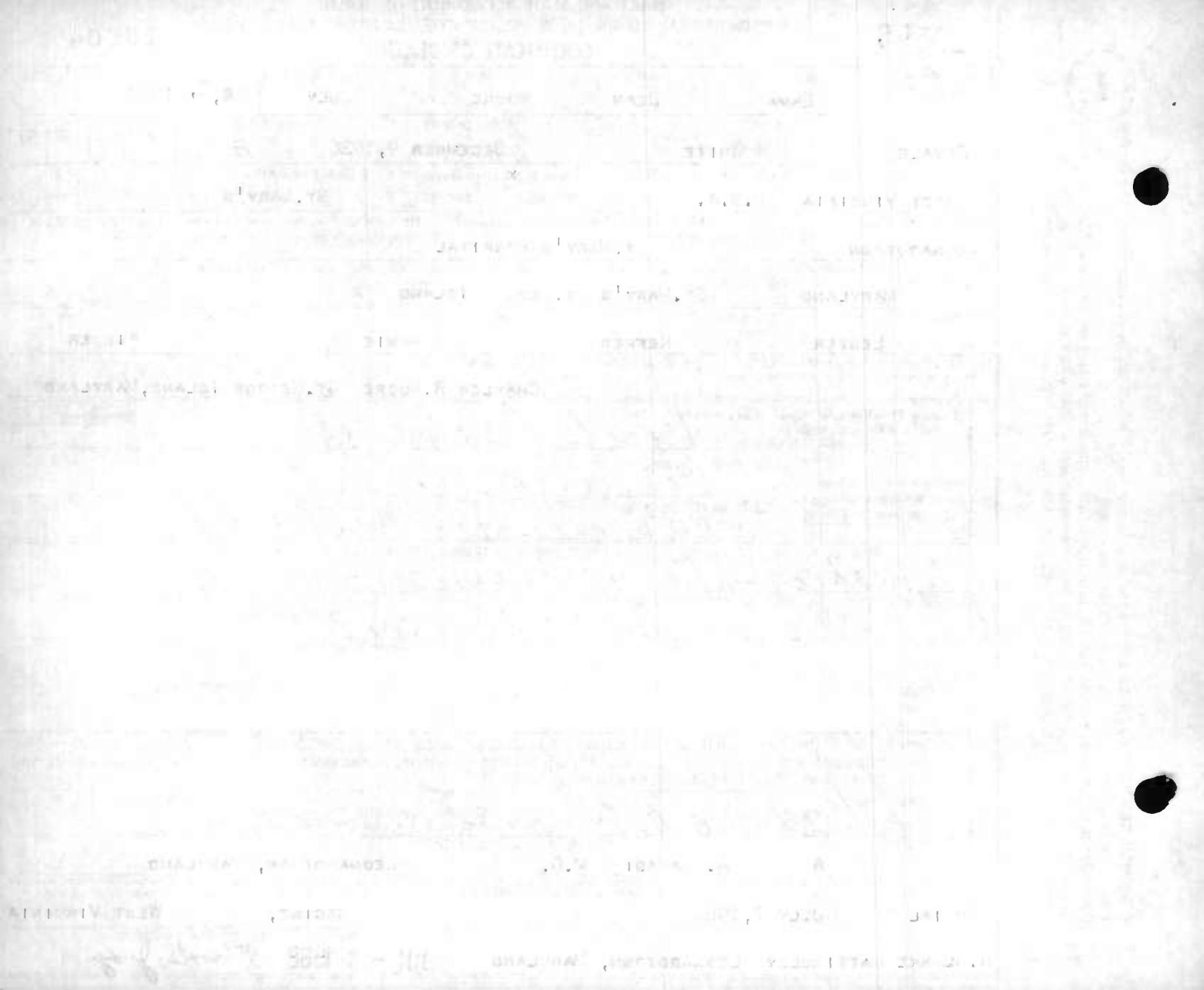
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1. DECEASED-NAME (Type or print)		First ERMA	Middle JEAN	Last MOORE	2a. DATE OF DEATH JULY Month 3, 1968 Day Year	2b. HOUR 11			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 9, 1928		6. AGE (In years last birthday) 39 YRS.			
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ST. MARY'S			
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13c. CITY OR TOWN ST. MARY'S		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME LESTER		First KEFFER	Middle KEFFER	Last MAMIE	15. MOTHER'S MAIDEN NAME MAMIE		Middle KINDER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes, no, or unknown		16b. SOCIAL SECURITY NO. 174-1708		17. INFORMANT CHARLES R. MOORE		Address ST. GEORGE ISLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1708 (b) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma right breast DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Metastatic carcinoma of brain									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma right breast		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 1968 , to 1968 , that (I) (we) last saw the deceased alive on 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. Samadi		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED 8/8/1968
22d. PHYSICIAN'S NAME (Type) A. SAMADI M.D.		22e. ADDRESS LEONARDTOWN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 7, 1968		23c. NAME OF CEMETERY OR CREMATORIAL RACINE,		23d. LOCATION (City or Town) RACINE,		(County) WEST VIRGINIA	(State)
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE Charles J. Clark			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

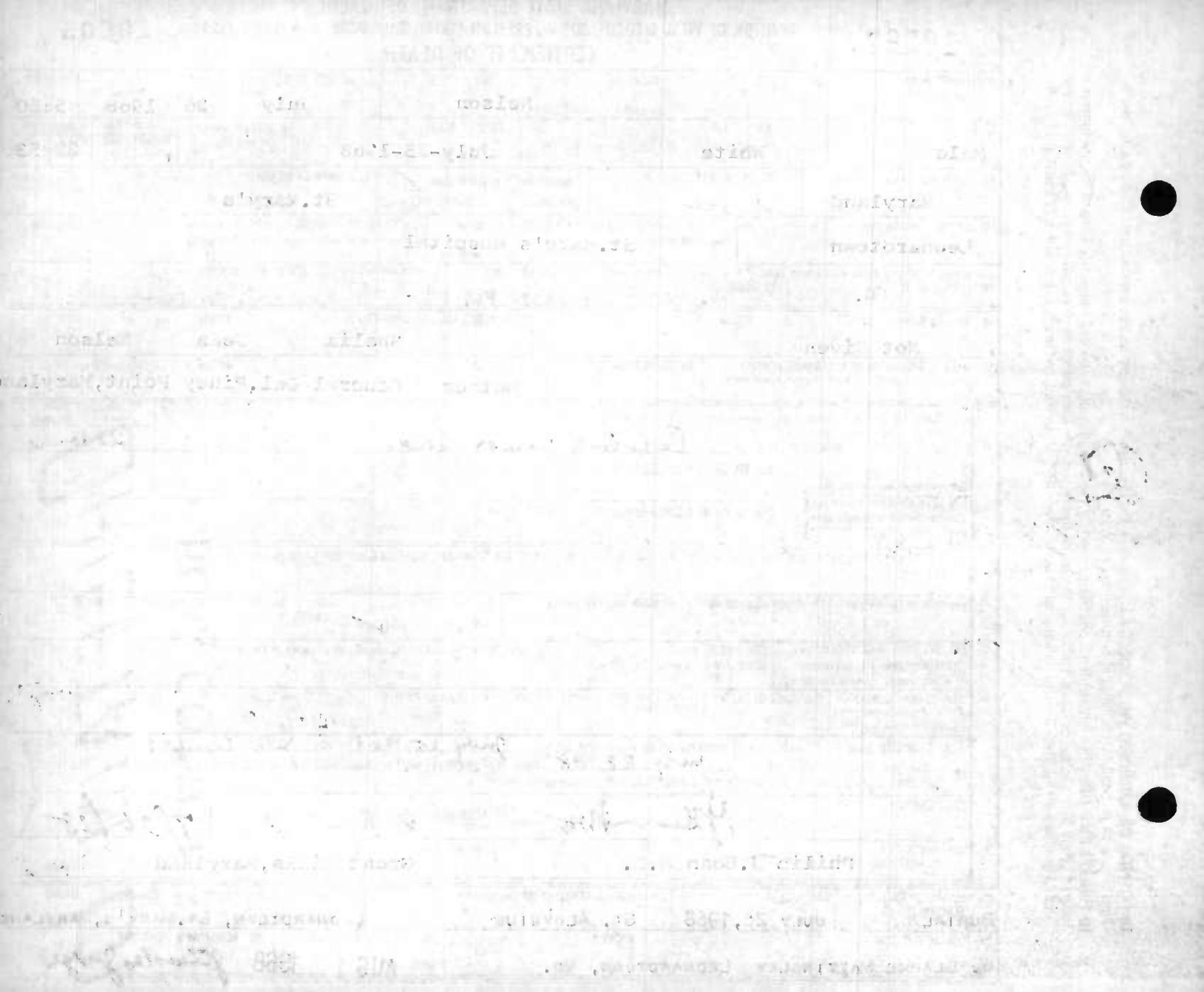


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Year	2b. HOUR
				Nelson	July	26	5:20 A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
Male		White		July 25 1968		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH	
Maryland		USA		<input type="checkbox"/> NEVER MARRIED	<input checked="" type="checkbox"/> WIDOWED	St. Mary's	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Leonardtown		St. Mary's Hospital		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		Piney Pt.	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER
Md.		St. Marys				General Delivery	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle
		Not Given			Shelia	Jean	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Yes, no, or unknown				Mother	General Del. Piney Point, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>22 hours</u>							
7720 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 7600							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>July 25, 1968</u> , to <u>July 26, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Philip J. Bean M.D.</u>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>7/26/68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		Great Mills, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)	
BURIAL		JULY 26, 1968		ST. ALOYSIUS		LEONARDTOWN, ST. MARY'S, MARYLAND	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. CLARKE MATTINGLEY		LEONARDTOWN, MD.		DATE AUG. 1 1968		Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

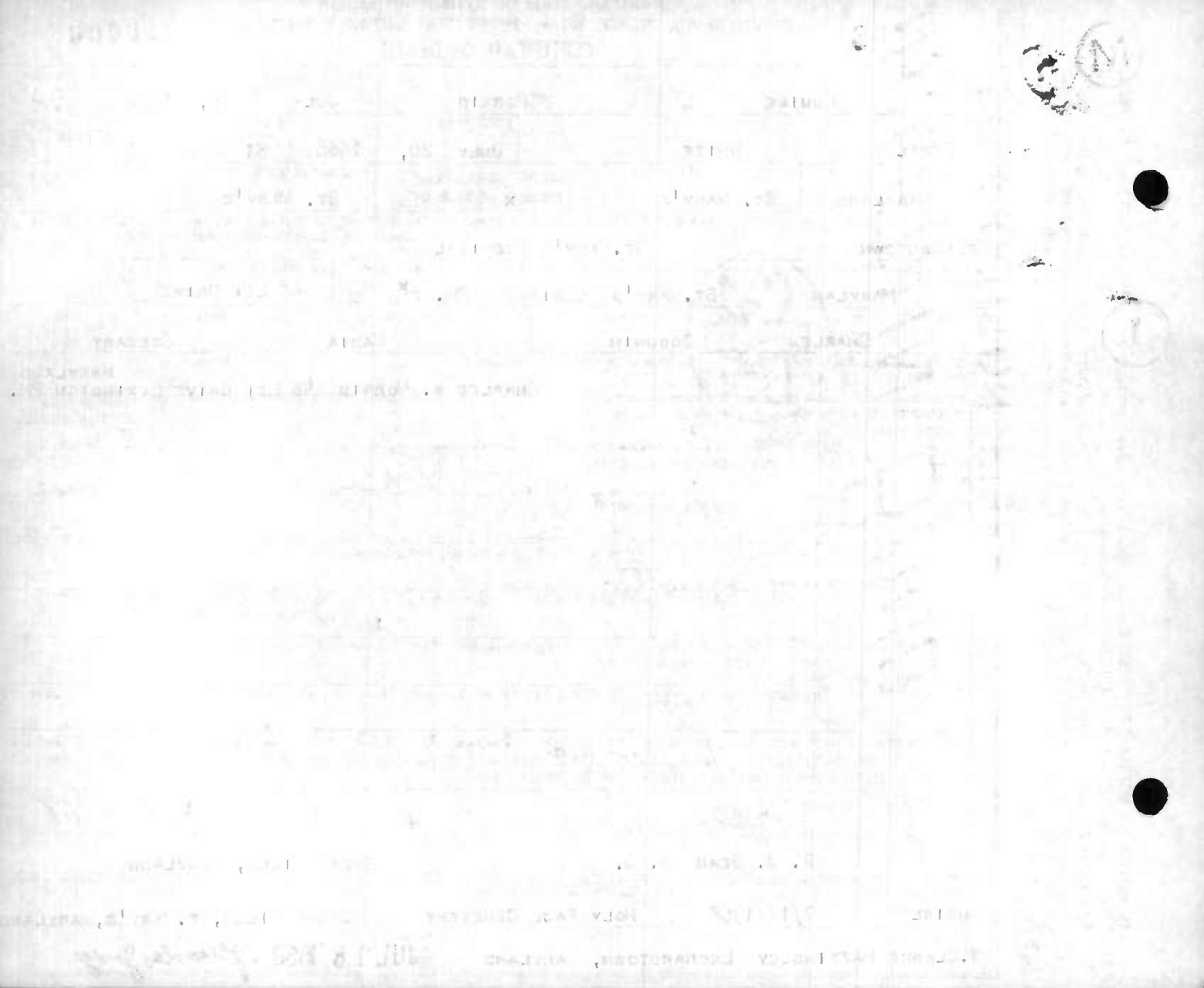
CERTIFICATE OF DEATH

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1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
2 Page 4 may be retained by the hospital or attending physician.
3 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	20. DATE OF DEATH Month	2b. HOUR						
		LOUISE L		NORRIS	JULY 15, 1968	9 A M						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.		
FEMALE		WHITE		JULY 20, 1886		81						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
MARYLAND		ST. MARY'S				ST. MARY'S						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
LEONARDTOWN		ST. MARY'S HOSPITAL										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
MARYLAND		ST. MARY'S		LEXINGTON PK.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		48 LEI DRIVE				
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost			
		CHARLES	GOODWIN		MARIA			STEWART				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address						
Yes, no, or unknown)				CHARLES A. NORRIS		48 LEI DRIVE LEXINGTON PK. MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> APPROXIMATE INTERVAL 4109 BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF <u>6 days</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) <u>Generalized arteriosclerosis</u> 6 years												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. MEDICAL CERTIFICATION		19b. PULMONARY CONGESTION		19c. DATE OF OPERATION		19d. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Doy Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 4, 1968</u> , to <u>July 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		<u>P. J. BEAN M. D.</u>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>July 16/68</u>
22d. PHYSICIAN'S NAME (Type)		P. J. BEAN M. D.		22e. ADDRESS		GREAT MILLS, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)		
BURIAL		7/17/1968		HOLY FACE CEMETERY		GREAT MILLS, ST. MARY'S, MARYLAND						
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
W. CLARKE MATTINGLEY		LEONARDTOWN, MARYLAND		JUL 18 1968		Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then it should be removed carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First CLEMENTINE	Middle HOWARD	Last SHOFFNER	2a. DATE OF DEATH JULY 28, 1968	2b. HOUR M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH DECEMBER 1, 1897		6. AGE (in years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S	12b. KIND OF BUSINESS OR INDUSTRY COUNTY
10. CITY OR TOWN OF DEATH LEONARDTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SCHOOL BUS DRIVER	12b. ADDRESS COUNTY
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND	13b. COUNTY ST. MARY'S	13c. CITY OR TOWN VALLEY LEE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER VALLEY LEE, MARYLAND	
14. FATHER'S NAME First JOSEPH	Middle CLEMENT	Last CRADDOCK	15. MOTHER'S MAIDEN NAME First CORA	Middle IRENE	Last HOWARD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT VAN D. SHOFFNER			
Address VALLEY LEE, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF, (b) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Hypocardial insarction					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c) 4201					
19a. DATE OF OPERATION 4201	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dr. Clarke M. D.	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Doy Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 65 Valley Lee, 1968	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE JAMES P. DARBOE M. D.		22c. DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED 7/29/68
22d. PHYSICIAN'S NAME (Type) JAMES P. DARBOE M. D.	22e. ADDRESS GREAT MILLS, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 30, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. GEORGE EPISCOPAL	23d. LOCATION (City or Town) (County) (State) VALLEY LEE, ST. MARY'S, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY	25a. REC'D BY REGISTRAR DATE AUG 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

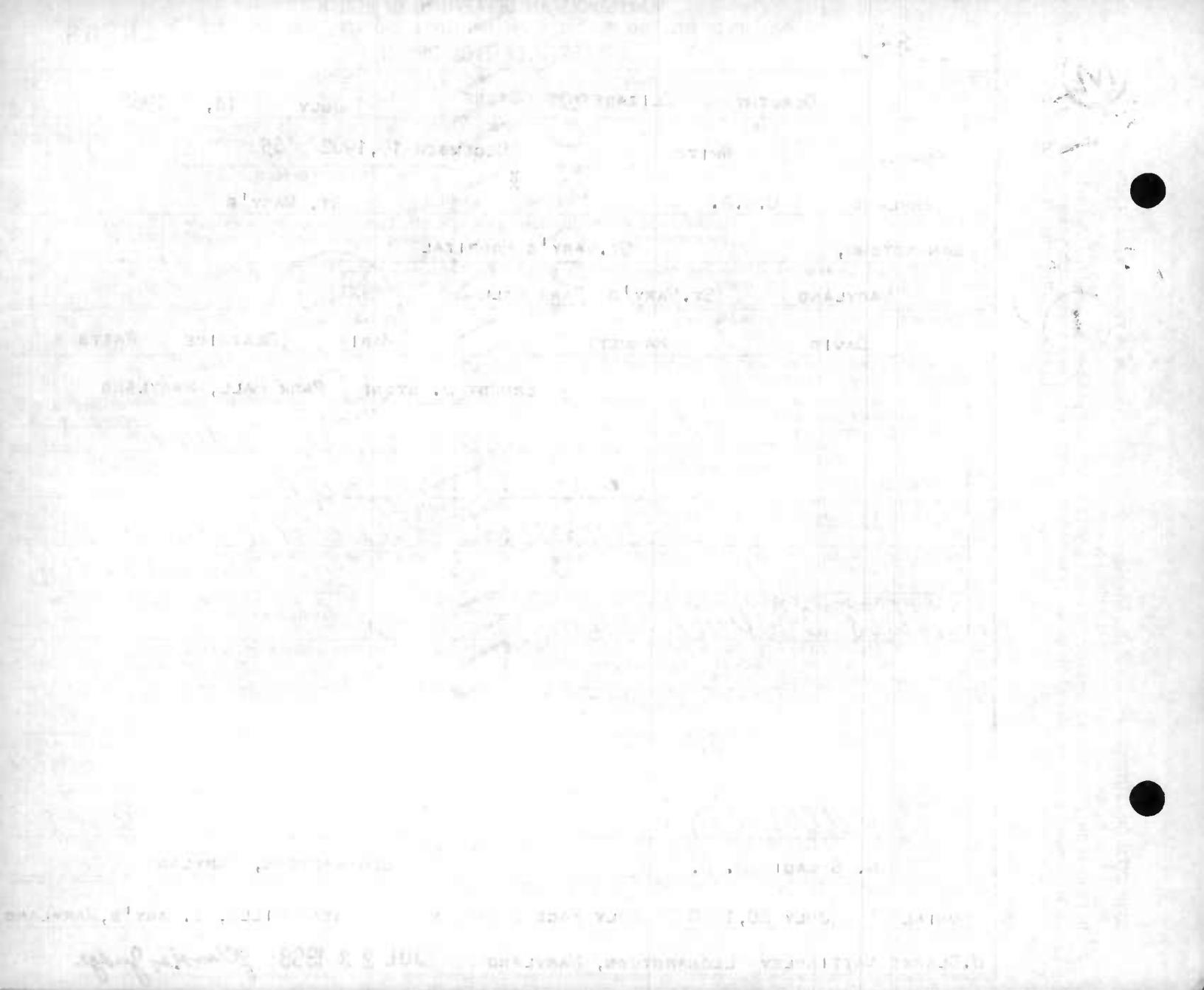
CERTIFICATE OF DEATH

10608

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) DOROTHY ELIZABETH STONE				2. DATE OF DEATH Month JULY Day 18 Year 1968	2b. HOUR M		
3. SEX FEMALE		4. RACE WHITE	5. DATE OF BIRTH DECEMBER 10, 1902	6. AGE (In years birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ST. MARY'S			
10. CITY OR TOWN OF DEATH LEONARDTOWN,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARY'S	13c. CITY OR TOWN PARK HALL	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER PARK HALL, MARYLAND		
14. FATHER'S NAME First DAVID Middle HAMMETT Lost		15. MOTHER'S MAIDEN NAME First MARIA Middle BEATRICE Lost					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.	17. INFORMANT	Address ERNEST L. STONE PARK HALL, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure - liver failure APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obstructive jaundice BETWEEN ONSET AND DEATH 1550 (c) Circumflex of the papille Valsalva metastasis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a 1551							
19a. DATE OF OPERATION 7/16/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive jaundice		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 7/14/68 , 19 68 , to 7/18 , 19 68 , that (I) (we) last saw the deceased alive on 7/18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Samadi		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 7/19/68		
22d. PHYSICIAN'S NAME (Type) A. SAMADI M. D.		22e. ADDRESS LEONARDTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JULY 20, 1968	23c. NAME OF CEMETERY OR CEMETORY HOLY FACE CEMETERY	23d. LOCATION (City or Town) GREAT MILLS, ST. MARY'S, MARYLAND		(County) GREAT MILLS, ST. MARY'S, MARYLAND	(State)
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE JUL 23 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

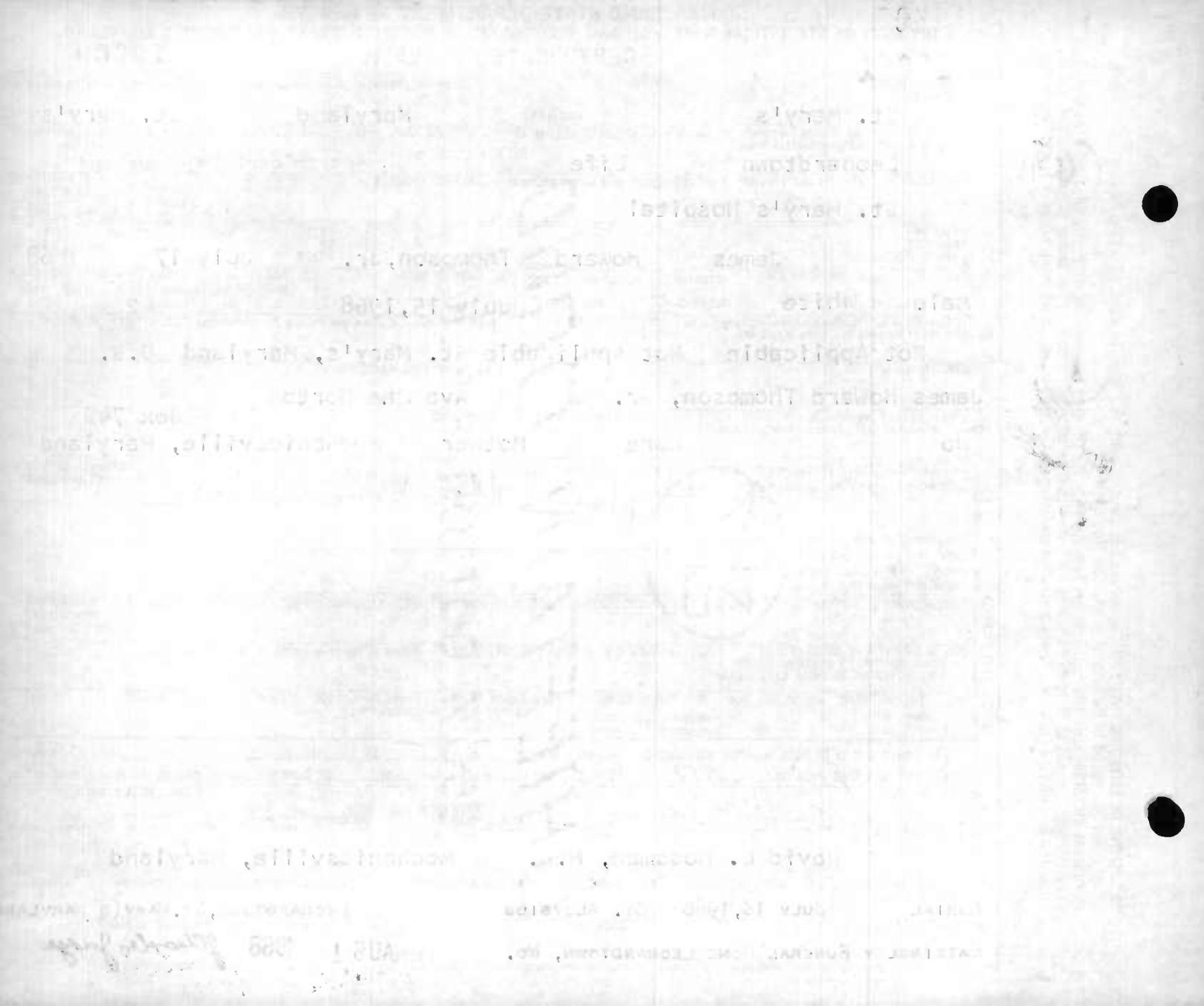


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper, pages 1 and 2, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
10601 10609
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE				
St. Mary's MARYLAND		Maryland St. Mary's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b				
Leonardtown		Life				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				
St. Mary's Hospital		Box 74C, Mechanicsville, Maryland				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First James	Middle Howard	Last Thompson, Jr.	4. DATE OF DEATH July 17	Month 1968	Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 15, 1968	9. AGE (In years last birthday) — yrs.	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? St. Mary's, Maryland U.S.
Not Applicable		Not Applicable				
13. FATHER'S NAME James Howard Thompson, Sr.		14. MOTHER'S MAIDEN NAME Ava Mae Horton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mother		Address Box 74C Mechanicsville, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776.1		Hyline Membrane disease		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 773.0		DUE TO				
(c)		DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
19						
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7/18/1968, and that death occurred at M, from the causes and on the date stated above.		19		19		19
22a. SIGNATURE Loy L. Mossman				22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) David L. Mossman, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Mechanicsville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 18, 1968		23c. NAME OF CEMETERY OR CREMATORIUM ST. ALOYSIUS		23d. LOCATION (City, town or county) (State) LEONARDTOWN, ST. MARY'S MARYLAND
24. FUNERAL DIRECTOR MATTINGLEY FUNERAL HOME LEONARDTOWN, MD.		ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

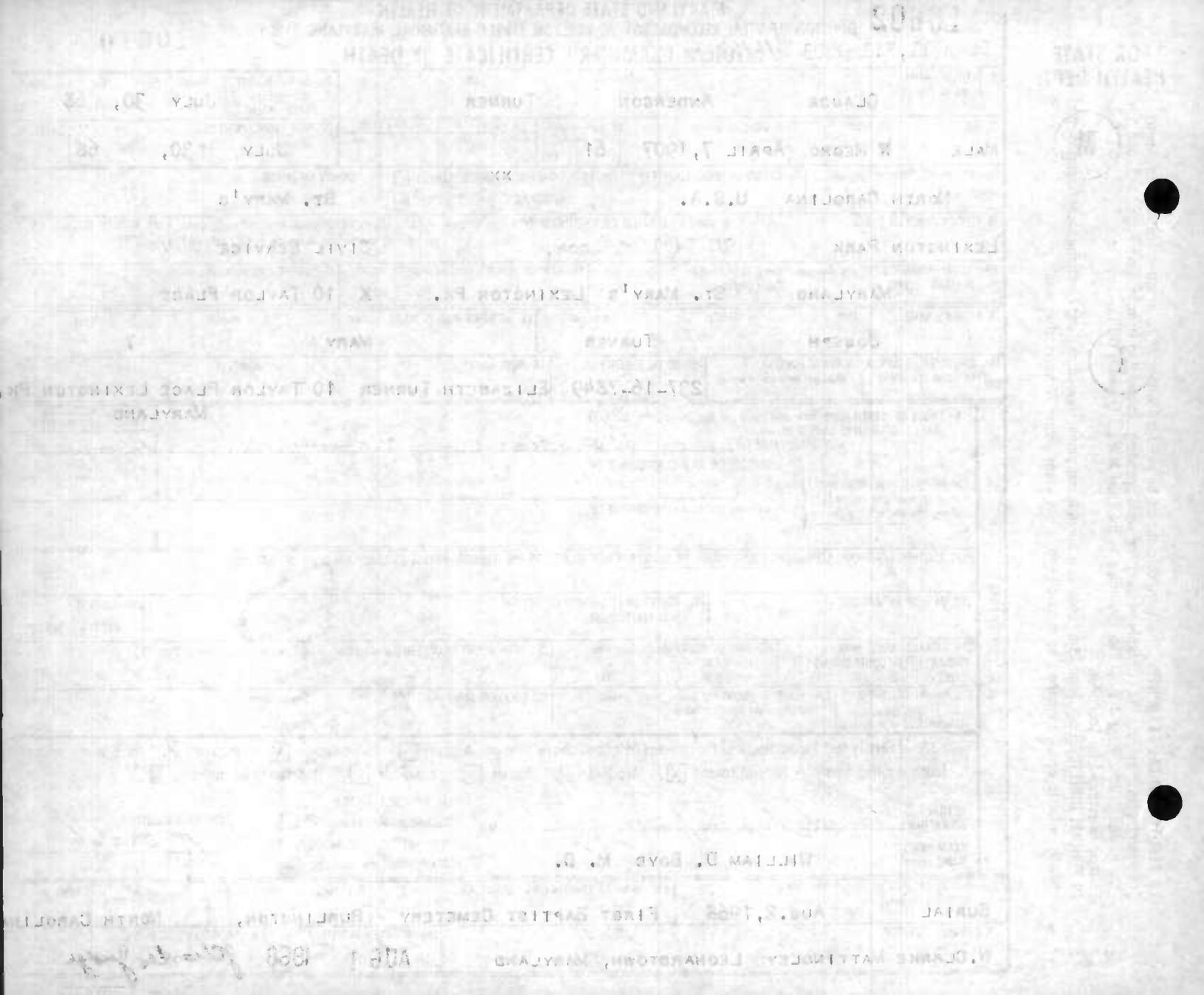


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year
CLAUDE ANDERSON TURNER						<input type="checkbox"/>			JULY	30	1968
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2b. HOUR					
MALE	NEGRO	APRIL 7, 1907	61 YRS.	MONTHS	DAYS	MONTHS	DAY	MIN	M		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD			2d. HOUR				
NORTH CAROLINA	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	ST. MARY'S	JULY	30	1968	M				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
LEXINGTON PARK	10 Taylor Place,			CIVIL SERVICE							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
MARYLAND	ST. MARY'S	LEXINGTON PK.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	10 TAYLOR PLACE							
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	16. ?	Lost			
JOSEPH		TURNER		MARY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	16c. INFORMANT	ADDRESS								
	237-16-7849	ELIZABETH TURNER	10 TAYLOR PLACE LEXINGTON PK								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Coronary infarction</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> (b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
420.1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>William D. Boyd</i> M.D.											
EXAMINER'S NAME (Type)											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL											
23b. DATE AUG. 2, 1968			23c. NAME OF CEMETERY OR CREMATORIAL FIRST BAPTIST CEMETERY			23d. LOCATION (City or Town) BURLINGTON, (County) (State) NORTH CAROLINA					
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY			ADDRESS LEONARDTOWN, MARYLAND			25a. REC'D BY REGISTRAR DATE AUG 1 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15ME (5) 10M REV. 1/68											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10611

10603

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First BENJAMIN	Middle OSBORNE	Lost UNKLE	2a. DATE OF DEATH Month JULY	Day 3	Year 1968	2b. HOUR M								
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH APRIL 25, 1908	5. AGE (In years last birthday) 60 YRS.	6. IF UNDER 1 YEAR MONTHS 0				7. IF UNDER 24 HRS. HOURS 0							
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH ST. MARY, S												
10. CITY OR TOWN OF DEATH LEONARDTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY, S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CONTRACTOR				12b. KIND OF BUSINESS OR INDUSTRY BUILDER							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	13b. COUNTY ST. MARY, S	13c. CITY OR TOWN ST. INIGOES	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER											
14. FATHER'S NAME First JOSEPH	Middle UNKLE	Lost	15. MOTHER'S MAIDEN NAME First SARAH	Middle				Lost							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 4109	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-16-1242	17. INFORMANT JOSEPH B. UNKLE	Address 507 ENTERPRISE DR. LEXINGTON PARK MD.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Laryngeal Collapse DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Rupture DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201															
19a. DATE OF OPERATION 4/20/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State								
22a. I certify that (I) (his hospital) attended the deceased from saw the deceased alive on 7/3/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE James P. Jarboe	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED JULY 5, 1968										
22d. PHYSICIAN'S NAME (Type) J. PATRICK JARBOE M.D.	22e. ADDRESS GREAT MILLS MARYLAND														
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 7/6/1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. MICHAELS	23d. LOCATION (City or Town) RIDGE				(County) ST. MARY, S. MD.		(State)						
24. FUNERAL DIRECTOR John M. Welch	ADDRESS LEONARDTOWN MD.				25a. REC'D BY REGISTRAR JULY - 9 1968	25b. REGISTRAR'S SIGNATURE Charles J. Jones									

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